



**Maternal and Child Health Services
Title V Block Grant**

**State Narrative for
Florida**

**Application for 2011
Annual Report for 2009**



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I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.

An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

Assurances and certifications are on file in with the Department of Health's central office. The assurances and certifications can be made available by contacting:

Bob Peck
Florida Department of Health
Bin A-13 (HSFFM)
4052 Bald Cypress Way
Tallahassee, FL 32399-1723

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

Public input begins with the Healthy Start coalition local needs assessment process and service delivery plan development and implementation. Consumer experience surveys and focus groups are heavily relied on for needs assessment, plan development, and ongoing implementation, and consumers serve on the coalition boards. Coalitions encompass minority participation on the boards, and emphasize minority input in their assessment of local needs. Headquarters MCH staff review and evaluate coalition needs assessments, service delivery plans, and implementation reports and use this information in planning MCH programs.

We will make the application available over the Internet on our department website. Applications from previous years, and the current application when it is final, are at <http://www.doh.state.fl.us/family/mch/docs/grant.html>. You may also find this page by going to the Department of Health webpage at www.doh.state.fl.us. On that page, go to the A-Z list pull down menu and click on maternal and child health. From there, click on the documents link, click on the link for MCH documents, and then click on the link for the MCH Block Grant Application. You can also reach the DOH website by going to www.myflorida.com and clicking on the "Find an Agency" link, and then clicking on the link for health.

II. Needs Assessment

In application year 2011, the 2010 Needs Assessment will be attached to this Section II.

An attachment is included in this section.

C. Needs Assessment Summary

The needs assessment process resulted in the identification of the following issues as priority needs for the Florida maternal and child health population, including children with special health care needs:

1. Prevent unintended and unwanted pregnancies.
2. Promote preconception health screening and education.
3. Promote safe and healthy infant sleep behaviors and environments.
4. Prevent teen pregnancy.
5. Improve dental care access, both preventative and treatment, for children.
6. Increase access to medical homes and primary care for all children, including children with special health care needs.
7. Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.
8. Increase early intervention services for children with special health care needs.

Selection of priority needs for this assessment included the consideration of quantitative and qualitative data. There was substantial input from key stakeholders and providers. A needs assessment advisory group was formed that consisted of key partners in maternal and child health as well as consumer representation. This advisory group made initial recommendations using a nominal group process. There was consensus among the group especially around the issues pregnancy prevention, preconception health screening and education, and promoting safe infant sleep behaviors. Increasing access to primary care and medical homes for children, particularly children with special health care needs was also identified as a priority need, as well as increased early intervention services and health care transition.

III. State Overview

A. Overview

Florida is the fourth most populous state in the nation, and the diversity of its population creates unique challenges. The Florida Legislature, Office of Economic and Demographic Research (EDR) estimates there were 18,818,998 residents in Florida in 2009. This represents a 17 percent increase over the 2000 EDR estimate of 16,074,896 residents for 2000.

According to the 2009 EDR estimates, females account for 51 percent of the total population. There are 4,150,372 children under 18, which is 22 percent of the total population. Estimates indicate there are 3,302,610 residents 65 or older, 17.5 percent of the total. Of those, 524,289 or 2.8 percent of the total are 85 or older. Of the total population, 80.7 percent are white, 16.5 percent black, and 2.8 percent are nonwhite other. Florida residents also reflect diverse ethnicities, as evidenced by the 24 percent who are identified as Hispanic. Of all residents over 5 years of age, 23.1 percent speak a language other than English at home.

The diverse population creates unique challenges for the Title V program. The programs within Title V must tailor services to meet the needs of different cultures. We produce pamphlets and other educational materials in English, Spanish, and Haitian Creole. Efforts are made to ensure clinic staff represents the diversity of their local clients. The Title V program and both private and public health faces additional challenges in meeting the needs of tourists, illegal immigrants, and other temporary residents in Florida.

Florida is a temporary home to over 80 million tourists and visitors each year. This constant influx places a significant burden on the health care system. Migrant farm workers and other undocumented aliens are also populations that create significant impact on public health services and resources. According to a report by the Pew Hispanic Center, Florida was home to 1,050,000 illegal immigrants in 2008, following only California and Texas, and accounting for 9 percent of the total illegal immigrants in the nation.

Historically, many illegal immigrants have come to Florida seeking jobs, particularly in agriculture. Construction jobs and service-related jobs have recently seen tremendous increases in the use of illegal immigrants as a source of cheap labor. Following a trend in the 1990s that saw some advancement in the pay and benefit opportunities for immigrant labor, recent trends indicate pay is decreasing and services are becoming scarcer.

The large illegal immigrant population can have a taxing effect on the social service system, as illegal immigrants and their families need medical care and other services as well. Medicaid costs for just the births for this population are staggering. For example, Medicaid paid approximately \$15.3m for 5,332 deliveries to undocumented aliens in state fiscal year FY98-99. A decade later, that amount increased to over \$85.4m for 18,220 deliveries in FY08-09. This does not include births to illegal immigrants for which the hospital absorbed the cost. Children born here to immigrant families are U.S. citizens. Without the same advantages of others, many of these families face generations of poverty-level existence, creating the possibility of years of public support and costs.

The geography of Florida can also create challenges in both the delivery of services and the response to events or disasters. With a total area of 58,560 square miles, Florida ranks 22nd among states in total area, though 4,308 square miles are covered by water. Driving from Pensacola in the western panhandle to Key West at the southernmost point is nearly an 800 mile journey. The 1,197 miles of coastline become a target during hurricane season, and 2,276 miles of tidal shoreline are subject to concerns regarding water quality and fish and wildlife habitat degradation.

With the threat of tropical depressions and hurricanes looming every summer, the Department of

Health has published a Family Preparedness Guide for residents and visitors as a tool that includes items such as: a fill-in family plan for disasters and emergencies, steps for making a disaster supply kit, and facts about natural and man-made threats. The guide is posted on the department's website, and is available in English, Spanish, and Creole. Disaster preparedness was tested in 2004 when Florida was hit with four major hurricanes and a tropical depression within a two-month period.

Florida's shorelines are facing a more prolonged threat this year, the oil spill in the Gulf of Mexico. Oil from this ecological disaster is likely to have an adverse affect on tourism, commercial and recreational fishing, and the many businesses supporting or supported by those industries. Tourism is a \$65 billion a year industry that directly employs over one million people in Florida, and any serious setback in tourism greatly reduces revenue needed to sustain government services and infrastructure.

Unemployment continues to be a concern in Florida. In March 2010, the unemployment rate in Florida was 12.3 percent, the highest rate since 1970 when records began. In April, the rate dropped to 12 percent, which was still considerably higher than the national rate of 9.9 percent. An unemployment rate of 12 percent means that 1.1 million residents of the state are currently unemployed and looking for work. Additional residents who have been unemployed long-term or who have given up on finding work are not included in that total. Many who become unemployed lose health insurance coverage for themselves and their families.

Like many states, Florida is facing ever-increasing Medicaid costs. For many indigent families and the working-poor, whose jobs offer salaries below the federal poverty level with no medical benefits, Medicaid is the sole source of health care coverage. Yet even those who qualify may have difficulty receiving care, as the number of providers who accept Medicaid does not keep up with service needs. The 2010 Florida Legislature introduced a bill that would have established a Medicaid Managed Care Program, requiring that all Medicaid recipients be assigned to an HMO. The legislation did not pass during the current session, but it did set the stage for possible Medicaid reform next year.

Addressing racial disparities in health outcomes continues to be an important focus of the Department of Health. In March 2005, the department hosted the 2005 Closing the Gap Summit, where national, state and local leaders, community-based organizations, health care professionals, and residents gathered to address this year's topic, Working Towards a Common Vision: Reducing Racial and Ethnic Health Disparities. The summit was held by the DOH Office of Equal Opportunity and Minority Health to address ways to decrease the morbidity and mortality rates in seven targeted diseases: cardiovascular, cancer, diabetes, HIV/AIDS, maternal and infant mortality, adult and child immunizations, and oral health care.

In an effort to address racial disparities in birth outcomes, the 2007 Florida Legislature passed a law creating a black infant health practice initiative. The purpose of the initiative was to review infant mortality in selected counties in order to identify factors in the health and social services systems contributing to higher mortality rates among black infants, and to produce recommendations on how to address the factors identified by the reviews. Broward, Dade, Duval, Gadsden, Hillsborough, Orange, Palm Beach, and Putnam counties were selected for the study. The quantitative analysis involved utilizing the Perinatal Periods of Risk process. This revealed that the highest rate of black fetoinfant deaths occurred in the maternal health/prematurity period, which relates to a woman's health prior to pregnancy. As a result of the initiative, community action teams were formed in each county. The community action teams continue to address racial disparity issues within their communities. Recommendations from the study include: developing and implementing community education and outreach regarding racial disparity in infant mortality; focusing on strategies related to interconception care and education; focusing on infant safety including sleep position and safe sleep environment; working with providers on cultural sensitivity; reducing barriers to prenatal care; providing educational messages; reducing barriers to Medicaid; and improving father involvement during pregnancy.

and infancy.

Each year since 2002, the legislature has provided funding for Racial and Ethnic Disparity: Closing the Gap projects with a primary focus of addressing racial and ethnic disparity in the seven target areas listed above. Projects receiving funding are selected through a competitive bid process. Currently funded maternal and infant mortality projects focus on issues such as: access to prenatal care, education, advocacy, and public awareness; support and education to pregnant women and parenting women in at-risk black communities; early intervention services for Hispanic and Haitian women of childbearing age; education on effects of infections on preterm labor; identification of conditions associated with poor birth outcomes in black women, and maternal health risk factors with strategies designed to increase physical activity and improve eating habits.

In state fiscal year 2008/2009, six maternal and child health projects were awarded a total of \$831,693 in Reducing Racial and Ethnic Health Disparities, Closing the Gap Act funding. For state fiscal year 2009/2010, six projects were awarded a total of \$683,905. Maternal and infant mortality services promote good health before pregnancy (preconception care). Supports include community outreach and education; individual health risk screens; healthy lifestyle education; and medical referral and follow-up for women at risk for preterm labor and poor birth outcomes. Three projects focus on the health risks of women of African-American descent; two projects focus on both African-American and Hispanic women; and a new project provides "Promotoras" (community leaders as lay health workers) for Hispanic women in five farm worker communities, spanning seven Florida counties.

To help address the needs of American Indians in Florida, the Department of Health formed an American Indian Advisory Council. This advisory group is part of the Minority AIDS Network and is comprised of six American Indian representatives from across the state. The council is lead by an Elder and includes members with HIV/AIDS program experience, general medical experience, counseling in drug and alcohol abuse, and a leader in tribal dance, as we understand dance is an important part of religious and holistic healing ceremonies. This council will serve as part of our massive effort to address HIV/AIDS disparities among all racial/ethnic minorities. They will bring the voices of the Native American community together in an advisory role to discuss and address issues they are facing in providing HIV prevention and care services to their communities.

The council voted to keep their focus on HIV education and cancer prevention at this time. The council is interested in addressing other needs as well, but there are trust and cultural tradition issues that must be addressed first. It is hoped that a Tribal Consultation to be held sometime in the summer of 2010 will allow the department to establish further trust and bonds, and gain a better understanding of the health needs of this vast and divergent population. The 2,000 U.S. Census counted over 117,000 American Indians in Florida, although community leaders feel that estimate is much too low. With more than 581 different tribes, bands, and clans in the state, addressing the various cultural needs can be a challenge, but the effort is an important one, as we work to help improve the lives of a population that is so important to the heritage of our state and nation.

Preventing obesity is another major issue for the department. The Healthy Communities, Healthy People (HCHP) program provides health promotion activities in each of Florida's 67 counties. One of the primary objectives is to increase healthy eating habits and physical activity among people of all ages. They provide technical assistance and support for local Healthy Start initiatives geared toward pregnant women and infants. We are discussing the potential to provide Chronic Disease Self-Management programs to women postnatally, possibly through the Centering Pregnancy format for prenatal care.

The department works closely with the Department of Education to provide technical assistance and resources to schools to support their wellness efforts. We also contract with four school districts to provide district wellness coordinators who establish and support wellness programs for

district school employees. This models healthy behavior in the school setting and provides opportunities for increased physical activity and healthy eating to pregnant women within the school system. The HCHP staff in 10 counties also support a Robert Wood Johnson Foundation grant that focuses on childhood obesity prevention as a model project for community mobilization.

The Hispanic Obesity Prevention and Education Program (HOPE) was developed to provide nutrition education and obesity information geared to the Hispanic population, including women of childbearing age. The online portion of the project remains active although the program is no longer funded.

In an effort to address adolescent issues, the department created the Positive Youth Development Program in June 2009. The purpose of the program is to enhance the skills and improve the health status of adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations throughout Florida. The program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the assets of individual youth and their families. In the first year, the program provided eight grants to local county health departments to deliver positive youth development programs and activities in their communities. Positive Youth Development sponsored programs reinforce positive attitudes, healthy behaviors and activities, and reduce risk-taking behaviors, such as sexual activity, substance abuse, suicide and behaviors that increase risk of unintentional injury and chronic disease. Since its inception in 2009, more than 4800 youth and 600 parents have been served through the program.

Priorities identified in the 2010 needs assessment are summarized in Section II C and discussed at length in the 2010 Florida Needs Assessment.

B. Agency Capacity

The State Title V agency's capacity to promote and protect the health of all mothers and children begins with Healthy Start. Healthy Start is the primary delivery system for preventive and primary care services for pregnant women, mothers and infants. Healthy Start helps pregnant women and infants obtain the health care and social support they need to reduce the risks for maternal and infant death and to promote good health and developmental outcomes. These efforts include not only assurance of access to health care, but also identification and intervention for psychosocial risks including incidence of domestic violence, substance abuse, potential child abuse, or neglect.

Healthy Start includes the Healthy Start Prenatal and Infant Coalitions, who have the legislative authority and responsibility to plan and develop improved local MCH service delivery systems. Through an allocation methodology developed at the state level, state and federal funding, including MCH block grant funding, is distributed to local Healthy Start coalitions to support infrastructure building and the provision of services to the MCH population. Healthy Start also includes universal risk screening for all pregnant women and infants, and care coordination services for eligible participants.

Other MCH projects include the Pregnancy Associated Mortality Review (PAMR) project and the Fetal and Infant Mortality Review (FIMR) project. The PAMR project is a population-based surveillance and selective state level case review process aimed at reducing the maternal mortality rate. The FIMR project is a community-based collaborative effort to establish a continuous quality improvement mechanism for communities that focuses not only on the medical aspects of prenatal and infant health care delivery systems, but also on the psychosocial, environmental and structural processes that contribute to fetal and infant deaths, and simultaneously complement the community-based nature of the Healthy Start coalitions.

Quarterly conference calls with all the funded FIMR projects in Florida address issues and

opportunities identified by the local FIMR projects and allow the department to provide information and guidance to the projects. The FIMR project representatives use these calls to share information and best practices with each other. The Division of Family Health Services epidemiologist is also available to assist local FIMR projects on an as needed basis.

Additional capacity is provided through the DOH Bureau of Epidemiology, which includes: periods of risk analysis to look at the proportional contribution of various periods to fetal and infant mortality; environmental epidemiology, addressing factors such as lead poisoning; birth defects surveillance; and the Pregnancy Risk Assessment Monitoring System (PRAMS). PRAMS is a continuing random survey of mothers of Florida newborns, designed to provide information about risk factors for adverse pregnancy outcomes and ill health in newborns. A cooperative agreement between the Centers for Disease Control (CDC) and the Florida Department of Health to conduct population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, PRAMS generates data used for the planning and evaluation of prenatal health programs.

The 67 county health departments across the state provide a variety of direct services to the MCH population; however, more and more county health departments are working with community providers to ensure services are delivered, rather than providing the services themselves. These services vary throughout the state and may include pregnancy testing, HIV pretest and post-test counseling, prenatal care, family planning, immunizations, periodic health history and physical examinations, preconception and interconception education and counseling, laboratory screening tests for health indicators such as lead and anemia, developmental screening, risk assessment, provision of anticipatory guidance, accident prevention, and substance abuse prevention education.

County health departments are responsible for ensuring students have access to quality health services that assess, protect and promote their health and ability to learn. Over 2,000 health staff personnel provide more than 18 million services to approximately 2.6 million K-12 students in 3,300 schools. The basic school health services provided to all public school students are: nursing and nutritional assessments; student health record reviews to ensure physical exam and immunization requirements are complete, and that appropriate services are provided for any chronic or complex health conditions; first aid; medication administration; complex medical procedures; age/grade appropriate screening for vision, hearing, growth and development, and scoliosis; emergency health services for students who are injured or become acutely ill at school; health education classes; parent and staff consultations on student health issues that interfere with school participation; and consultation for placement of students in exception education programs. Comprehensive and Full Service school health programs provide a broad range of health and social services in addition to basic school health services, in schools with high numbers of high-risk and medically-underserved children. Comprehensive school health provides significant emphasis on prevention of high risk behaviors, pregnancy prevention and support services for pregnant and parenting teens.

The Florida Department of Health Children's Medical Services (CMS) program provides children with special health care needs, from birth to age 21, a family-centered, comprehensive, and coordinated statewide managed system of care that links community-based health care with multidisciplinary, regional, and tertiary pediatric care. The CMS system of care includes a network of services that range from prevention and early intervention programs to primary and specialty care programs, including long-term care for medically complex children. CMS enrollees may receive medical and support services through 22 CMS area offices staffed by private physicians, in local private physician offices or other health care organizations, through regional programs, hospitals, referral centers and statewide specialty programs.

The CMSN serves as a managed care choice for Medicaid beneficiaries who must choose a managed care option. Families of Medicaid eligible children who meet the clinical screening criteria may choose CMSN as their provider. Services are reimbursed directly by Medicaid on a

fee-for-service basis. The Florida legislature directed CMS to maximize federal Titles XIX and XXI funds for its salaried staff. The CMS Program obtained federal approval to draw down Title XIX funds as a result of administrative claiming. In addition to the two CMSN insurance products (funded by Title XIX and Title XXI, depending on the child's income level), CMSN also provides the original Safety Net services for children with special needs who are not eligible for either of the other funding sources. CMS is also responsible for coordinating policy and procedures across departments that relate to children and youth for special health care needs and has responsibility for the Part C Program of the Individuals with Disabilities Education Act and a major responsibility for the newborn screening program.

CMS has adopted the Maternal and Child Health Bureau's National Goals as its six program goals and created performance measures for each:

Goal #1: All children who are enrolled in CMS Programs and their families will partner in decision-making at all levels and will be satisfied with the services they receive.

Goal #2: All children who are enrolled in CMS Programs will receive coordinated, ongoing, comprehensive care within a medical home.

Goal #3: All children enrolled in CMS Programs and their families will have the resources to fund services within the guidelines of the CMS Program.

Goal #4: All children will be screened early and continuously assessed for emerging or changing special health care needs.

Goal #5: CMS Offices will identify culturally competent, comprehensive community-based service systems for all children enrolled in CMS Programs and their families.

Goal #6: Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence.

Each CMSN enrollee is eligible to receive care coordination. The care coordinator is a critical link in the development of a medical home for the child and family. Care coordination services to all CMSN enrollees are documented in the CMS Child Assessment and Plan (CAP), a web-based application. CMS area office staff utilizes CAP to record patient assessments, care plans, and notes. The integration of the six national goals into the CMS program goals, performance measures and CAP further enhances the care coordination activities by ensuring the provision of ongoing, coordinated, culturally competent, comprehensive care, within the context of a medical home. A total of 70,000 CMSN children receive care coordination services and are linked to a medical home. Of the 70,000 children, 18,000 receive care coordination and services through the Early Intervention Program.

The CMSN Title V Director is a member of the national medical home advisory council supported by the American Academy of Pediatrics. The state was awarded a five-year CHIPRA demonstration grant and one component is training and evaluation of medical homes for children with special health care needs. This next year will be a planning year for the grant followed by two to three years of implementation and evaluation. Additionally, the AAP will provide training to about 10 pediatric practices in Florida on the use of the medical home toolkit followed by quality improvement activities that will be a collaborative effort between practices and the CMS Program. This training will occur during 2010-11.

In 2008, Senate Bill 988 / House Bill 793 called for the creation of a time-limited task force to address the needs of young adults with disabilities moving into adult health care systems in Florida. The main focus of the Health Care Transition Services Task Force for Youth and Young Adults with Disabilities is to "assess the need for health care transition services, develop

strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources." CMS led the establishment of a statewide task force created through a legislative initiative. The task force included members of stakeholders and state agencies in order to assess the need for health care transition services, develop strategies to ensure successful transition from pediatric to adult health care systems, and identify existing and potential funding sources. CMS has established local/regional health care transition coalition pilot sites to support health care transition initiatives on a local level. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other pertinent data. The local coalitions will also provide education and training activities for both consumers and providers; and advocate for improved health care financing strategies and policies. The initial meetings for the coalitions were held in January 2010.

The CMS Pharmacy Benefits Program (PBM) provides increased pharmacy access for families of CMS enrollees. CMS contracts with MedImpact Health Care Services to link with national, regional, and locally owned pharmacies throughout Florida to assist with the processing of prescriptions and to decrease waiting time for prescription refills, improve evening and weekend coverage, and provide a toll-free help desk to answer questions.

CMS, in coordination with Medicaid, has established 10 Children's Multidisciplinary Assessment Teams (CMAT) to provide cost containment, quality assurance, and utilization review for medically complex children receiving high cost, long-term medical services. CMAT functions through a multidisciplinary, inter-program, and inter-agency effort. Team members include the family and representatives from the Children's Medical Services and Early Steps Programs of the Department of Health, Child Welfare & Community Based Care of the Department of Children and Families, the Agency for Persons with Disabilities, and the Medicaid Program of the Agency for Health Care Administration, in addition to any other community based agencies that may be able to assist in the care of a child. CMS has lead responsibility to facilitate this collaboration.

The Department of Children and Families' Behavioral Health Network works in conjunction with CMS to address the behavioral health needs for children age 5 to 19 who are between 101 percent and 200 percent of the federal poverty level. Diagnoses covered include mood, psychiatric, or anxiety disorders; severe emotional disturbance; and substance dependence. Children who are eligible for Medicaid receive behavioral health services through Medicaid.

The Medical Foster Care (MFC) Program is a coordinated effort between the Florida Medicaid Program within the Agency for Health Care Administration, Children's Medical Services within the Department of Health, and the Child Welfare and Community Based Care (CBC) Program within the Department of Children and Families. To be eligible for the MFC program, children must be under the age of 21, be identified as needing medically necessary services to meet their medical complex condition, be in the custody of the Department of Children and Families, and be medically stable for care in the home setting. The MFC Program establishes and supervises the oversight and training of foster parents to provide MFC services for these children. Medical foster parents are Medicaid provider, child-specifically trained, and are responsible for performing most of the day to day functions necessary for the child's care. This program is a cost-effective alternative to hospitalization, long-term, in-home, private duty nursing, or skilled nursing facility placement. The program currently serves approximately 742 children per year.

Florida's Early Steps Program offers early intervention services to infants and toddlers from birth to 3 years of age with developmental delays or established medical conditions that place them at risk for developmental delay. Funding for this program is provided through Part C of the Individuals with Disabilities Education Act (IDEA), enhanced by state and local resources. It is suggested that pediatric practices could be better equipped to follow children's development and connect parents with community resources. Within the context of the CMSN medical home approach, Florida's early intervention program will provide for more efficient and comprehensive

primary care in partnership with parents. Early intervention services teach and empower parents to advocate and seek the services that their children need. Through 15 contracted local offices across the state, the goal of Early Steps is to increase opportunities for infants and toddlers with disabilities to be integrated into their communities and to learn, play, and interact regularly with children who do not have disabilities.

Florida's Newborn Screening Program provides screening for all newborns for certain metabolic, congenital, and hereditary disorders prior to discharge from the birthing facility. Florida screens statewide for 35 disorders. The primary goals of the program are: to ensure all newborns born in Florida are screened and testing is processed within two weeks of birth; to ensure all affected newborns receive appropriate confirmatory testing, counseling, and treatment as soon as possible; and to ensure all affected newborns are placed into a system of care in a timely fashion.

The CMS Early Hearing Loss Detection and Intervention (EHDI) program promotes universal newborn hearing screening, effective tracking and follow-up as a part of the public health system, appropriate and timely diagnosis of the hearing loss, and prompt enrollment in appropriate Early Intervention services. EHDI links newborns to a medical home and strives to eliminate geographic and financial barriers to service access. A component specific to serving families of children with hearing loss has been established in the Part C Early Steps program with ongoing emphasis on improving the number and quality of early intervention service providers.

The CMS Genetics Program provides genetic evaluation, diagnosis, and counseling for children with or at risk for having a genetic disorder. Services provided include initial and follow-up diagnostic and evaluation; genetic counseling; lab studies required for confirmation of genetic disorders; confirmatory testing for infants with abnormal test results for PKU and galactosemia; dietary consultation for treatment of PKU or galactosemia; and educational programs for CMS staff. The genetics telemedicine project enables a pediatrician and a University of Florida geneticist to communicate via two-way interactive video technology.

The Pediatric HIV/AIDS Program provides infants and children with HIV/AIDS access to a continuum of services through a network of seven Pediatric HIV Referral Centers and 10 CMS satellite clinics. Pediatric HIV Program services include evaluation, diagnosis, care coordination, nutrition counseling, permanency planning, assistance with transportation, and other support services. The HIV Program at the University of South Florida conducts monthly pre-clinic chart reviews with CMS staff in Ft. Myers via two-way interactive video technology. This enables the HIV specialist to see more patients during the satellite clinics in Ft. Myers. A similar arrangement occurs between CMS staff in Pensacola and the HIV specialist from the University of Florida prior to monthly satellite clinics. Over 1,350 infants and children enrolled in the CMSN received services at a Pediatric HIV Referral Center or CMS HIV Satellite Clinic.

CMSN has partnered with the Agency for Health Care Administration (AHCA) and Florida Hospices and Palliative Care to provide pediatric palliative care services to children with life-threatening conditions enrolled in CMSN. As the first publicly-funded palliative care program in the nation, the Partners in Care: Together for Kids (PIC:TFK) program provides palliative care from the time of diagnosis through the course of treatment. Palliative care services include pain and symptom management; patient and family counseling; expressive therapies; and respite, nursing and personal care. Services are provided to eligible CMSN children enrolled in the state's Title XXI program (KidCare), and under the 1915(b) Managed Care Waiver, allowing palliative care services to be extended to children with Medicaid who have life-threatening conditions. PIC:TFK is in the fifth year of implementation and is expected to be statewide by 2011. The Partners in Care: Together for Kids program has served over 1000 children since July 2005 by Title XXI, XIX and Safety Net.

The Department of Health, Children's Medical Services, Division of Prevention and Intervention, promotes the safety and well being of children in Florida by providing specialized services to children with special health care needs associated with child abuse and neglect. The division

consists of three units: the Child Protection Unit, the Prevention Unit, and the Special Technologies Unit.

The CMS Child Protection Team (CPT) Program is a medically led, multidisciplinary program based on the concept that child abuse and neglect involve complex issues and require the expertise of many professionals to protect children. CPTs supplement the assessment and protective supervision activities of the Department of Children and Families, child protective staff at local sheriff offices, and other community based care providers in reports of child abuse and neglect. There are 25 teams throughout the state to provide specialized assessments and services to child victims, siblings, and their families. Services provided may include: medical diagnosis and evaluation, medical consultation, forensic interviews of suspected child victims, specialized interviews of children and their family members, family psychosocial assessment, nursing assessment, psychological evaluation, multidisciplinary staffing, and expert court testimony. The CPTs handled 28,452 cases involving child victims and their families and provided 39,139 assessments per year.

The CMS Telehealth Program works with the CPTs to provide medical examinations of alleged child victims who are located in remote areas. CPT Telemedicine capabilities are now available at 17 service sites, which provided assessment for 378 children in 2009.

The CMS Sexual Abuse Treatment Program (SATP) promotes the safety and well-being of children in Florida by providing specialized, comprehensive, multidisciplinary assessment and treatment services for children who have experienced sexual abuse, their siblings, and their non-offending caretaker. SATPs work with child protective investigators and CPTs. Community agencies, individuals, and other professionals may also make direct referrals. The SATPs may provide therapeutic services for children (and their non-offending family members) who have been the victim of intrafamilial sexual or physical abuse or child on child sexual abuse. The number of SATP providers are 17; with all areas of the state having an area provider. The SATP served 5,716 child victims, their siblings and families in 2007-2008.

The CMSN works with the Special Technologies Unit to maintain the CMS contracted program with the University of Florida's (UF) pediatric endocrinology staff that provides telehealth services for CMS enrollees with diabetes and other endocrinology diagnoses served by the Daytona Beach CMS area office. The use of two-way interactive video technology has proven to be an effective way of ensuring the availability of expert medical services to outlying rural areas.

Other CMS telehealth and telemedicine initiatives include: a partnership with the Institute for Child Health Policy at the University of Florida to refer CSHCN who are seen at three of the state's community health centers to a CMS office for enrollment; nutritional, neurological, and orthopedic consults for CMS enrollees in Ft. Pierce, West Palm Beach, and Ft. Lauderdale; craniofacial team meetings; various educational presentations between CMS area offices; and numerous administrative and consultative meetings with CMS staff. Some CMS offices are beginning to work with the University of Miami to develop teledermatology clinics as well. The CPT is available in 17 sites.

CMS oversees the statewide Poison Information Center Network. Poison prevention and management information is provided 24 hours a day through a toll-free number. The centers provide access to poison information, triage of the potentially poisoned patient, collection of pertinent data, professional consultation for health care providers, and professional and consumer education. Since FY 2003-04, the Poison Centers received HRSA bioterrorism funds to develop, enhance, and maintain a system for rapid response to bioterrorism threats, natural disasters, and man-made disasters. The system involves real-time data reporting and analysis. During fiscal year 2007-08, the network handled 191,494 calls, provided 6,395 consults, provided education services to 1,766 community programs, 372 professional events, and participated in 824 health fairs or other special events. Over 500,000 pieces of informational materials and 78 media/public relation activities were provided.

CMS has responsibility for the Shaken Baby Syndrome/Abusive Head Trauma (SBS/AHT) information program. In fiscal year 2007-2008, over 350,000 Coping with Crying brochures (the SBS brochure) were distributed to all birthing facilities. The brochures and educational information are required to be given to parents of every newborn prior to hospital discharge. This initiative includes conducting training for hospital nurses to provide Coping with Crying education and coping strategies to new parents prior to discharge. A total of 43 facilities received the training and over 600 participants statewide viewed the distance-learning satellite broadcast Coping with Crying-Shaken Baby Syndrome Prevention.

The basic statutory authority for MCH is Section 383.011, Florida Statutes, Administration of Maternal and Child Health Programs. The statute authorizes the Department of Health to administer and provide MCH programs, including the WIC program and prenatal care programs. This statute also designates the Department of Health to be the agency that receives the federal MCH and Preventive Health Services Block Grant funds. Other statutes related to the MCH program:

Section 409.810, F.S., establishes Florida KidCare.

Section 154.01, F.S., authorizes the Department of Health to operate primary care programs through the county health department delivery system, establishing a system of comprehensive integrated care.

Section 91.297, F.S., provides the authority for the Department of Health to implement a comprehensive family planning program.

Section 381.0056, F.S., delineates the joint responsibilities and cooperative efforts the Department of Health and the Department of Education have in implementing the school health services program.

Section 381.0057, F.S., establishes comprehensive school health services to provide health services in the schools, to promote the health of students and to reduce teenage pregnancy.

Section 381.0052 (e), F.S., the Public Health Dental Program Act, makes available dental preventive and educational services to all citizens and treatment services to indigent persons.

Section 383.014, F.S., authorizes screening and identification of all pregnant women entering into prenatal care and all infants born in Florida, for conditions associated with poor pregnancy outcomes and increased risk of infant mortality and morbidity.

Section 383.216, F.S., establishes prenatal and infant coalitions for the purpose of establishing partnerships among the private sector, the public sector, state government, local government, community alliances, and MCH providers and advocates, for coordinated community-based prenatal and infant health care.

The basic statutory authority for CSHCN and their families is Chapter 391, Florida Statutes, known as the Children's Medical Services Act. Related statutes include statutory authority and mandates pertaining to: screening of infants for metabolic and other hereditary and congenital disorders; infant hearing impairment; perinatal and neonatal services; child protection; sexual abuse treatment; developmental evaluation and intervention; hematology; oncology; poison centers; and parent support and training programs. Other statutes related to the Children's Medical Services Program:

Section 383.144, F.S., Infant Hearing Impairment Program.

Section 383.15-.21, F.S., Regional Perinatal Intensive Care Centers Program.

Section 383.215, F.S., Developmental Intervention and Parent Support and Training.

Sections 415.5055, 415.5095, F.S., Child Protection Teams.

Section 402.24 F.S., Recovery of Third Party Payments for Medical Services.

Chapter 385, F.S., Chronic Disease, Hematology/Oncology Care Centers Program.

Section 395.038, F.S., Regional Poison Control Centers.

Chapter 187, F.S., State Comprehensive Plan.

Section 409.905, F.S., Early and Periodic Screening, Diagnosis and Treatment Services.

Chapter 411, F.S., Florida Prevention, Early Assistance and Early Childhood Act.

98.282, Florida Laws, Healthy Start Act.

Section 383.14, F.S., Screening for metabolic disorders, other hereditary and congenital

disorders, and environmental risk factors.
Section 383.145, F.S., Newborn and infant hearing screening.

C. Organizational Structure

The Florida Department of Health is directed by the State Surgeon General, who answers directly to the Governor. The Surgeon General is responsible for overall leadership and policy direction of the department. The Surgeon General is assisted by the following key staff:

Chief of Staff: responsible for Communication and Marketing, and assists with policy direction.

Deputy Secretary: responsible for Administration, Legislative Planning, Medical Quality Assurance, Office of Public Health Research, Women's Health, Correctional Medical Authority, and Health Access and Tobacco.

Deputy Secretary for Health and Director of Minority Health: responsible for Minority Health, Health Statistics and Assessment, Disease Control, Emergency Medical Operations, Environmental Health, and Family Health Services.

Assistant Deputy Secretary for Health: responsible for the County Health Departments.

Deputy Secretary for Children's Medical Services: responsible for Children's Medical Services, Disability Determination, and Information Technology.

The Florida Department of Health is responsible for the administration of programs carried out with allotments under Title V. Many of these programs fall within the auspices of the Division of Family Health Services and the Division of Children's Medical Services. The directors of these two divisions serve as the primary Title V contacts for the state, and play an important role in the Title V direction.

The Division Director of Family Health Services provides leadership, policy, and procedural direction for Family Health Services, which includes the bureaus of Family and Community Health, WIC and Nutrition Services, Public Health Dental, Chronic Disease Prevention and Health Promotion, and the Child Nutrition Program.

The Bureau of Family and Community Health is responsible for many of the Title V activities related to pregnant women, mothers, and infants; and children. The Chief of the Bureau of Family and Community Health directs the offices of Infant, Maternal, and Reproductive Health (IMRH); Child and Adolescent Health; and Adult and Community Health.

Programs within Infant, Maternal, and Reproductive Health include Title V, Family Planning (Title X), Healthy Start, Pregnancy Associated Mortality Review, and Fetal and Infant Mortality Review.

D. Other MCH Capacity

Following is a description of senior level management employees in lead positions.

Ana M. Viamonte Ros M.D., MPH, serves as the State Surgeon General of the Florida Department of Health. She is the first woman and the first Cuban American to lead the department. She came to DOH from Armor Correctional Health Services, where she worked to organize and monitor the health care delivery services in Florida's correctional institutions, and also oversaw the development of medical discharge programs.

Robert Siedlecki, Jr., was appointed Chief of Staff for the Florida Department of Health in March 2009. He previously served six years in the federal government with two agencies, at the Department of Health and Human Services as Special Assistant to the Assistant Secretary for Children and Families, and the Department of Justice as Senior Legal Counsel to the Task Force for Faith-Based and Community Initiatives.

Kim Berfield was named the Deputy Secretary for the Florida Department of Health in February 2007. Prior to joining the Department of Health, she served four terms as a representative in the Florida House. She served in numerous positions during those terms, including Chairman of the Insurance Committee and Chairman of the Republican Conference.

Shairi R. Turner, M.D., M.P.H., serves as both the Deputy Secretary for Health and the Director of Minority Health. Prior to joining the Department of Health, she served as the first Chief Medical Director in the Florida Department of Juvenile Justice, where she was responsible for assisting that department with the provision and oversight of quality medical, mental health, substance abuse, and developmental disability services.

Michael Sentman, Assistant Deputy Secretary for Health, is responsible for the oversight and direction of the 60 county health department directors and administrators responsible for the 67 county health departments in Florida. He has over 13 years experience at the county health department level, 10 of which was as an Administrative Services Director, and over five years at the department level.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 25 years experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

The Title V programs are distributed among the Division of Family Health Services and Children's Medical Services Program, which has two divisions. As of May 2010, there are 30 central office staff in the Division of Family Health Services, Bureau of Family and Community Health, who perform duties for Title V funded programs. There are approximately 2,000 county health department staff who create the local infrastructure for Title V funded programs. The senior level management employees include: Annette Phelps, A.R.N.P., M.S.N., Division Director for Family Health Services, State Title V Director and Terrye Bradley, M.S.W., Bureau Chief, Family and Community Health. Capacity is also provided through the 30 Healthy Start coalitions covering 65 of the 67 counties in Florida. Department of Health county health departments serve as the Healthy Start coalition in the other two counties. Additional capacity is provided through partnerships with the private sector, the public sector, state government, local governments, community alliances, and maternal and child health care providers, and through linkages with state and national work groups and associations that provide capacity building by enhancing current competencies for staff and technical assistance.

Annette Phelps, A.R.N.P., M.S.N., has served as the Division Director for Family Health Services since 2002. Prior to that, Ms. Phelps served as the Bureau Chief for Family and Community Health, and was the Executive Community Health Nursing Director in the Office of Maternal and Child Health (now known as Infant, Maternal and Reproductive Health). Before joining the Central Office staff in 1989, Ms. Phelps worked for a number of years in county health departments.

Katherine Kamiya, M.Ed., serves as the Assistant Division Director for Family Health Services. She joined the division in 2007, bringing over 25 years of experience in direct services, administration, and executive leadership with addressing the needs of at-risk children and families. In this role, Ms. Kamiya also coordinates orientation, training and professional development activities, as well as legislative bill tracking for the Division of Family Health

Services.

Terrye Bradley, M.S.W., joined the Department of Health in 2002 to become the Bureau Chief of the Bureau of Family and Community Health. Ms. Bradley's prior experience includes serving as the Chief of Volunteer Services in the Department of Juvenile Justice, and as the Chief Operating Officer for an eight-site Community Health Center. She also worked several years as an administrator within a community-based hospice program.

William M. Sappenfield, M.D., M.P.H., joined the Division of Family Health Services in 2005. Dr. Sappenfield serves as the director of the MCH Practice and Analysis Unit. The main role of the unit is to enhance and support policy and program decision-making through surveillance, health monitoring, epidemiology investigations, evaluation, training, and capacity building.

Kris-Tena Albers, A.R.N.P., C.N.M., M.N., joined the Division of Family Health Services in 2008 as the Executive Community Health Nursing Director in the Infant, Maternal, and Reproductive Health Unit, which includes programs related to maternal and infant health and the Family Planning Program. Ms. Albers experience includes work within the department in the Office of Public Health Preparedness and in Public Health Nursing. She has also worked as a certified nurse midwife, an adjunct instructor for nursing students, and in nursing positions focusing on women's health.

Additional capacity within the Infant, Maternal and Reproductive Health Unit includes the following personnel:

Margaret Rankin, R.N. B.S.N., serves as the leader of the Family Planning Program, and has worked in Family Health Services since 1998.

Carol Scoggins, M.S., joined the Infant, Maternal, and Reproductive Health in October 2009, serves as the leader of the Quality Improvement Team, and has worked in Family Health Services since 2004.

Nicole Hill joined Infant, Maternal, and Reproductive Health in November 2009, and serves as the Project Administrator.

Karen Coon, A.R.N.P., M.S.N., joined Infant, Maternal, and Reproductive Health in July 2010, and serves as the leader of the Healthy Start contracts team, and has previous experience working in the bureau of Family and Community Health as well as CMS.

As of May 2010, there were approximately 79 central office staff members in the Children's Medical Services Program. The CMS Network Division performs the duties for the Title V children with special health care needs component. There were approximately 673 out-stationed staff members in the 22 CMS area offices located throughout the state. The senior level management employees include: Joseph Chiaro, M.D. Deputy, Secretary for CMS; Phyllis Sloyer, R.N., Ph.D., Division Director for CMS Network and Related Programs; Michael Haney, Ph.D., Division Director for CMS Prevention and Early Interventions Programs, Marybeth Vickers, R.N., MSN., Chief for CMS Network Operations Bureau, and Peggy Scheuermann, M.Ed., Deputy Division Director for CMS Prevention and Early Interventions Programs.

Joseph Chiaro, M.D., was appointed as the Deputy Secretary for Children's Medical Services in January 2005. He has 30 years experience as a CMS physician provider and served eight years as the medical director for the Orlando (Region IV) CMS region. Dr. Chiaro spent 18 years in pediatric critical care medicine at the Arnold Palmer Hospital for Children and Women, and is board certified in Pediatrics and Pediatric Critical Care.

Phyllis Sloyer, R.N., Ph.D., has served as the Division Director for Children's Medical Services since 1996 and is the Title V CSHCN Director. Prior to that Dr. Sloyer has served in several

managerial positions in Children's Medical Services since 1979. She also served as Associate Director of the National Center for Policy Coordination at the Institute for Child Health Policy from 1990 to 1993 and has extensive experience in developing systems of care for CSHCN. She has also been recognized as Florida's Public Health Woman of the Year, has served as treasurer of AMCHP, and is the President of AMCHP. She serves on the Florida Developmental Disabilities Council.

Michael L. Haney, Ph.D., CCISM, NCC, LMHC, has served as the Division Director for Prevention and Intervention since 1998. Previously, Dr. Haney worked with the Department of Children and Families as Bureau Chief for Family Safety and Preservation, Children's Home Society as Coordinator for Family Preservation Services, as a mental health consultant, trainer and hostage negotiator, as a Clinical Supervisor for mental health services, and as an adjunct instructor in general and adolescent psychology at St. Johns River Community College and in the School of Social Work at Florida State University.

Mary Beth Vickers, R.N., M.S.N. joined CMSN as Chief for CMS Network Operations Bureau in June 2010. Previously, Ms. Vickers served a variety of CMSN programs in the nursing consultant role, as well as the Director of the Quality & Practice Management Unit. During her tenure with the Department of Health she has worked as a Nursing Consultant with the Florida Board of Nursing, and as the Executive Director of a Home Health Agency. Ms. Vickers is an adjunct instructor in nursing at Florida State University and Tallahassee Community College.

Peggy Scheuermann, M.Ed., C.P.M., has served as the Deputy Division Director for the Children's Medical Services Division of Prevention and Intervention, and has been with the division since 1998. Prior to working for the Department of Health, Ms. Scheuermann worked for a variety of social services agencies in the areas of criminal justice, domestic violence and child welfare. She currently serves on several statewide advisory councils on substance abuse prevention and child welfare.

Charlotte Curtis, R.N., B.S.N., C.P.M., has worked with the Department of Health since 1998. Prior to joining CMS in January 2006, as the Executive Community Health Nursing Director for the Partners in Care: Together for Kids Program/CHIPACC, she served as a Nursing Consultant for the Maternal and Child Health Unit and Executive Community Health Nursing Director for the Child and Adolescent Health Unit. Ms. Curtis has been instrumental in the development, implementation and expansion of the first publicly funded palliative care program in the nation, and provides technical assistance to other states who would like to replicate Florida's palliative care model. Ms. Curtis is an adjunct instructor in nursing at Florida State University, and serves as a preceptor for senior nursing students.

E. State Agency Coordination

The Department of Health collaborated with the University of Florida, the Florida Chapter of the March of Dimes, and the Agency for Health Care Administration as sponsors of a summit meeting for providers, health care plans, families, and other interested parties held June 10, 2010. The theme of the summit was Developing Florida's Perinatal Quality Collaborative. The purpose of the collaborative is to improve the understanding of possible root causes of adverse birth and infant outcomes for Florida residents. Once established, the group will measure infant and birth outcomes and the effect of generated perinatal interventions to address those outcomes, monitor and share key perinatal care indicators, identify and address statewide priority quality improvement issues, and provide quality improvement components for health providers and health plans at a state and provider level. Findings will be reported to state and local leaders, the public, health providers, health plans, and other agencies and organizations, in order to strengthen initiatives and minimize duplication.

The Department of Health provides or coordinates public health services through headquarters

programs, county health departments, CMS area offices, primary care associations, and tertiary care facilities. Services are often provided in collaboration with other state agencies, including: education; juvenile justice; corrections; social services; child welfare; Medicaid and SCHIP; social security; emergency medical services; and alcohol, drug abuse, and mental health. This effort focuses on health and preventive care services, the promotion of optimal health outcomes, and the monitoring of the health status of the population.

In order to present an integrated, seamless service delivery system to families of vulnerable children, the Division of Family Health Services works in close collaboration with Children's Medical Services to ensure communities have procedures for coordinating services to those eligible for both Healthy Start and the CMS Early Steps Program.

School health services are provided under the direction of the Department of Health and in cooperation with the Florida Department of Education. Comprehensive school health service projects provide health care services in schools with high incidences of underserved high-risk children, teenage pregnancy, and poor birth outcomes.

Under Title XXI and Medicaid, the MCH role in the State Children's Health Insurance Program is to ensure access to care through outreach and the eligibility application process, provide interagency coordination, and staff the KidCare Coordinating Council. CSHCN are served through the CMS Network. The Florida KidCare plan provides services to children under 200 percent of the federal poverty level from birth to age 19 through either a Medicaid managed care plan, MediPass, or through the Title XXI programs, MediKids and Florida Healthy Kids. MediKids is for children age 1 to 5.

The Department of Health works in partnership with the Department of Children and Families (DCF) and the Ounce of Prevention Fund of Florida on implementation of the Healthy Families Florida initiative. Healthy Families Florida provides a community-based approach that uses intensive home visiting and coordination with other support services to build an integrated, coordinated, and comprehensive system of support for the prevention of child abuse and neglect. The agencies work together to avoid duplication of services and to facilitate services needed by families served in either program.

In addition, the Department of Health has a letter of agreement with the Department of Children and Families that details collaboration between the two agencies to facilitate services for clients of both agencies. The letter of agreement includes interagency collaboration relating to facilitating the following health care services to DCF clients and its contracted service providers: HIV counseling, testing, and AIDS clinic services; family planning; Healthy Start; Early Intervention Program (Infants and Toddlers) services; prenatal care; immunizations; primary care/EPSTD; Special Supplemental Nutrition Program for Women, Infants, and Children (WIC); dental care; multiple handicap assistance teams; medical foster care; and other services as appropriate.

Coordination with WIC includes collaboration regarding breastfeeding initiatives, early entry into prenatal care, coordination with Healthy Start, addressing nutrition issues such as folic acid to prevent neural tube defects, and the development of general nutrition guidelines for inclusion in the Healthy Start standards. Coordination with other grant programs administered outside of the Department of Health includes working with Florida's Federal Healthy Start projects in selected counties, and other MCH-funded projects, including the Pediatric Pulmonary Project at the University of Florida, the MCH program of the College of Public Health at the University of South Florida, the Lawton and Rhea Chiles Center for Healthy Mothers and Babies, the Florida State University Center for Prevention and Early Intervention, and Community Integrated Services Systems (CISS) grants related to reproductive health and child abuse and neglect prevention.

Coordination with the Family Planning Program, which includes work on reducing teen pregnancy, reducing subsequent births to teens, preconception and interconception education

and counseling, and abstinence education, has long been an integral part of our MCH efforts. This relationship was further enhanced in 2003 when the Family Planning Program (formerly housed within Women's Health) merged with the Maternal and Child Health Unit, to form the Infant, Maternal, and Reproductive Health Unit. This reorganization reflects a desire to fully integrate women's health care through the preconception, prenatal, and interconception periods, in order to promote optimal health prior to and between pregnancies, to help ensure positive birth outcomes.

The Department of Health and the Department of Children and Families continue coordinated efforts to prevent substance abuse during pregnancy and to reduce the impact of children affected. An IMRH staff person serves on the Florida Substance Abuse Prevention Advisory Council, and the IMRH unit has had the lead on the Florida Fetal Alcohol Spectrum Disorders Interagency Workgroup. The Department of Health also is a co-sponsor of the annual statewide Substance Abuse Prevention Conference. In 2004, the Substance Abuse Program Office of DCF co-sponsored the IMRH unit's Partners Sharing Solutions Conference. The Department of Health works to increase the proficiency of health care providers in recognizing and getting needed treatment for women who abuse drugs during pregnancy and for substance-exposed infants, and in identifying and working toward resolution on issues impacting continuous and comprehensive prenatal and infant care for this high-risk population. One concrete example of these collaborations is Fetal Alcohol Spectrum Disorders -- Florida Resource Guide, which has been included on CSAP's FASD Center for Excellence website as a recommended resource. The guide may be seen at <http://www.doh.state.fl.us/family/socialwork/pdf/fasd.pdf>. The interagency accomplishments of the FASD Workgroup earned the group a Davis Productivity Award in 2004.

In an effort to ensure that we continue to employ best practices to help reduce infant mortality, the Department of Health and the Florida Association of Healthy Start Coalitions have assembled a statewide Research to Practice Workgroup. The purpose of the workgroup is to review existing and ongoing research to ensure the continued effectiveness of the Healthy Start model. The workgroup will employ evidence-based practices to evaluate the Healthy Start program at the state and local levels, providing program improvements through the identification, implementation, and evaluation of best practices across the state.

The department works collaboratively with Florida universities to implement maternal and child health initiatives. These collaborations enable the state to access resources unique to the university setting. The Perinatal Data/Research Center, located at the University of Florida, provides a warehouse for maternal and child health data. The center stores and validates data, links related data files, publishes and analyzes data, and studies the impact of program interventions on health status outcomes. The department also serves as a site for public health, nursing, and social work interns from Florida A&M University and Florida State University.

Community health centers play an important role in Florida's health care delivery system. There are 41 community health centers in Florida and 283 clinic locations, though not every clinic provides a full-range of services. Centers are located in 54 of the 67 counties in Florida. Funded in part by the U.S. Public Health Service, they provide care in federally designated medically underserved areas. The centers offer primary health care, preventive health services, emergency medical services, transportation services, preventive dental care, and pharmaceutical services. Their patients include high-risk clients such as migrant farm workers, low birth weight infants, the elderly, homeless people, and HIV patients. A number of Healthy Start coalitions contract with the centers for prenatal care and infant services, based on need and available resources. In some areas, the centers play an active role as members of the local Healthy Start coalition, which might include activities such as service delivery planning.

The Department of Health has implemented programs that address many of the leading causes of death for women including the Heart Disease and Stroke Prevention Program, the Comprehensive Cancer Control Program, the Breast and Cervical Cancer Program, the Colorectal Cancer Control Program, and the Diabetes Prevention and Control Program.

Programs addressing morbidity in women include the Arthritis Education and Prevention Program, Tobacco Cessation and Control, and the Communities Putting Prevention to Work Program (addressing obesity and tobacco prevention and control).

The Heart Disease and Stroke Prevention Program (HDSPP) was developed to prevent and reduce the burden of cardiovascular disease in Florida. This program's priority strategies focus on controlling high blood pressure and cholesterol, recognizing signs and symptoms of heart attack and stroke, the importance of calling 911 in an emergency, improving emergency response, improving quality of care, and eliminating health disparities between population groups. The HDSPP brings together diverse public and private organizations to coordinate resources and collaborate to improve the overall cardiovascular health in Florida. Program initiatives include School District Employee Wellness programs in a pilot project involving Polk, Nassau, Sarasota and Osceola counties and expanding quality improvement systems change in the federally qualified community health centers.

The Florida Comprehensive Cancer Control Program (CCC) works to reduce the burden of cancer in Florida on individuals, families, and communities by improving communication, coordination, and collaboration among public and private organizations at local, regional, and state levels. Initiatives from CCC that have impact for youth and families include: Sun Protection in Florida (SPF), which utilizes the "Sun Wise" curriculum for elementary school children and provides sturdy shade shelters for participating schools; and Grow Healthy, which is a collaborative venture between CCC and the Department of Education that encourages schools and community groups to emphasize healthy foods and physical activity through small garden projects.

The Diabetes Prevention and Control Program (DPCP) was created to reduce the burden of diabetes and the health-related complications of Floridians with diabetes by improving the access to, and quality of, diabetes care. This program has implemented strategies for increasing patient advocacy; promoted medical practice guidelines to improve healthcare standards; promoted the use of community health workers to connect community members to the formal health system; trained Healthy Start staff on the Road to Health Curriculum to prevent diabetes in women with gestational diabetes and others at-risk, and provided technical assistance to all county health departments on diabetes issues.

The Healthy Communities, Healthy People (HCHP) Program provides funding, training and guidance to all 67 county health departments to develop, implement, and support environmental and policy strategies to promote healthy life choices and reduce death and disability from chronic disease. Prevention efforts, focusing on healthy eating and active living, are accomplished through collaboration with local partners and coalitions for community-wide impact. Local focus areas include worksites, schools, health care settings, and organizations, including faith-based organizations.

The Communities Putting Prevention to Work Program (CPPW), funded by the American Recovery and Reinvestment Act, consists of two components. Component I focuses on obesity prevention and tobacco cessation/prevention through policy and environmental change promoted by 13 regional coordinators located throughout the state. These activities include increasing physical activity through participation in the Safe Routes to School -- Walking School Bus Program, increasing support for lactating employees of state agencies and school districts, and increasing the number of tobacco-free parks and recreational facilities.

Component II of CPPW provides resources to implement an evidence-based, comprehensive physical activity program in all 590+ Florida middle schools. Training will be delivered to designated teachers in years one and two and Train the Trainer training will be conducted in the summer of year two to certify future trainers in an effort to assure sustainability of this program. The decline in the amount of physical activity that children engage in begins in middle school; however, students who are physically active in middle school have a greater likelihood of

becoming physically active adults. Adults who are physically active significantly reduce their risk of heart disease, stroke, and other chronic diseases such as diabetes. It is expected that this future generation of healthier adults will result in reduced future healthcare costs.

Florida utilizes funding from HRSA through the State Systems Development Initiative Grant Program (SSDI) to enhance and improve statewide data capacity. Efforts have included: establishing and improving linkages between existing data files; developing and expanding local level data access and capacity; expanding the agency's data capacity for national reporting; and increasing the evaluation and analytic activities for MCH issues. Immediate goals include: improve access to linked and unlinked files for the department, for state partners and for Florida communities while protecting confidentiality and program integrity; improve accuracy, efficiency and sustainability of current file linkage activities; and improve use of linked and unlinked files for policy and program purposes. The ultimate goal of the SSDI grant is to have information needed to improve the health of women, children and families in a useable format that is readily available to people who can make decisions at individual, family, neighborhood, community, or state levels.

In the fall of 2008, the Infant, Maternal, and Reproductive Health Unit successfully applied for the HRSA First Time Motherhood/New Parents Initiative. Grant funding in the amount of \$223,362 enabled us to partner with the Healthy Start Coalition of Pinellas, Inc. on a project entitled Florida Right from the Start. The project will create a statewide social marketing campaign to promote positive birth outcomes by increasing awareness of preconception and interconception care, prenatal care, and parenting among first time parents. An evaluation team will gauge the effectiveness of the social marketing campaign based on increased awareness as measured by pre-intervention and post-intervention surveys. They will administer Web-based surveys to a convenience sample of first-time mothers and parents. They will also conduct Web-based post-implementation key informant surveys, and compile utilization statistics from the website and hotline to evaluate actual use. Funding for the second year is \$230,064.

F. Health Systems Capacity Indicators

Introduction

Following is a discussion of each individual Health System Capacity Indicator.

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	40.9	37.1	39.2	35.0	20.3
Numerator	5307	4910	4375	3932	2311
Denominator	1298296	1323696	1117411	1122596	1136801
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than 5 years of age is calculated with inpatient hospital discharge data from the Florida

Agency for Health Care Administration (AHCA) and population data for children 0 -- 5 from Florida Community Health Assessment Resource Tool Set (CHARTS) - <http://www.floridacharts.com/charts/PopQuery.aspx>.

There were a number of efforts in FY 2009 to reduce early childhood asthma. The Healthy Start program assesses pregnant and parenting mothers for issues related to household indoor air quality, such as use of tobacco products, appropriate removal of dust and animal dander, and other allergens. Additionally, the Infant, Maternal, and Reproductive Health Unit works to reduce the prenatal smoking rate that includes education to pregnant mothers on the relationship between secondhand smoke sudden infant death syndrome, lung problems, ear infections, and more severe asthma. Mothers or their infants and children are referred for medical specialty care if asthma is suspected.

The Department of Health, Division of Environmental Health inspects daycare and pre-kindergarten facilities. The state asthma data workgroup tracks the relationships between environmental asthma triggers and rates of asthma hospitalization and student asthma. Hospital discharges for asthma among 0 -- 14 year-olds decreased from 1.9 per 1,000 in FY2008 to 1.9 per 1,000 in FY2009. Although the activities above may have contributed to this decrease, the increased availability of new and effective asthma treatments for use in young children may have contributed substantially.

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	81.7	100.0	100.0	100.0	
Numerator	143510	139614	141849	140978	
Denominator	175700	139614	141849	140978	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	

Notes - 2009

Data for 2009 are not yet available.

Notes - 2007

Data for 2007 are not yet available.

Narrative:

Local organizations and communities initiate outreach activities to increase awareness of the availability of Medicaid coverage for eligible children, and the Florida KidCare partners ensures the public understands families may apply for and have their eligible children enrolled in Medicaid at any time. In addition, the Robert Wood Johnson Foundation Covering Kids Coalition is working to ensure that all eligible low-income children apply for Medicaid coverage through KidCare through collaboration with community, regional, and state organizations and KidCare community coalitions.

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	0.0	62.4	67.3	72.5	44.3
Numerator	0	965	1189	1004	402
Denominator	1	1546	1768	1384	907
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

In Florida, infants whose family income is <200 percent of poverty are eligible for Medicaid. A small number of families choose not to apply for Medicaid, instead opting for SCHIP coverage. The Agency for Health Care Administration collects data on the number of SCHIP enrollees who receive at least one initial or periodic screen and shares that with the Department of Health.

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	72.8	72.0	70.1	69.7	71.3
Numerator	143758	151987	150512	142059	137735
Denominator	197525	211215	214708	203696	193261
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The department works in collaboration with Healthy Start coalitions statewide to ensure an adequate infrastructure is in place for the provision of first trimester prenatal care and continuous care for all pregnant women. The MomCare program, implemented statewide during FY2002, facilitates Medicaid coverage for prenatal care under the Sixth Omnibus Budget Reconciliation Act (SOBRA). MomCare provides prenatal care choice counseling outreach, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive health related enabling services. MomCare sends a seven-month packet to all clients that includes information on the Family Planning Waiver. MomCare provides follow-up services as needed to recipients as well as a mandatory post-enrollment follow-up service to all recipients between the sixth and ninth

month of facilitating access to family planning services, health care coverage for the infant and help choosing a pediatrician for the infant. Follow-up can be by telephone or by mail. We continued to ensure the statewide process of presumptive and Simplified Medicaid eligibility for pregnant women. Additionally, we work through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	90.8	97.2	94.4	76.9	
Numerator	1577873	1415867	1478702	1360513	
Denominator	1737630	1456033	1566962	1768710	
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	

Notes - 2009

Data for 2009 are not yet available.

Notes - 2008

At the beginning of the fiscal year though (July 2008), AHCA switched fiscal agents and the entire Medicaid Management Information System was overhauled and upgraded. They are still trying to certify the data for FY2008.

Narrative:

The Florida KidCare partners continue to work with community-based organizations, health care providers, and others to ensure people understand the Medicaid program availability. The 2005 Florida Legislature approved continuous open enrollment for the Florida KidCare program; and although Medicaid eligible children always had access to coverage at any time during the year, the Title XXI eligible children currently have year-round access as well. In addition, the Robert Wood Johnson Foundation funded Covering Kids and Families project implemented special initiatives to work with hard-to-serve populations and leaders in minority communities to ensure that they promote the Florida KidCare message to eligible children year-round. These enabling services are targeted towards providing easy-to-understand, accurate information about the programs, and preventing loss of coverage among eligible children in the state.

The CMS program will ensure that families with Medicaid-eligible children with special health care needs are aware of the benefits of choosing the CMS Network as their child's health care provider. CMS arranged with the Department of Children and Families to include special needs questions in the initial Medicaid eligibility determination process and for eligibility redetermination. The goal is to identify early Medicaid-eligible children with special health care needs to inform their families about the CMS Network and the specialized health benefits it offers. If Medicaid eligible children with special health care needs are identified early and select the CMS Network before being subject to mandatory assignment, it can prevent breaks in continuity of care and ensure the children are enrolled in a coordinated system of care that uses pediatric providers and

specialists.

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	42.5	38.3	33.5	32.4	48.9
Numerator	103907	98114	104442	116656	144990
Denominator	244304	256216	312066	359656	296332
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Improving access to dental care for low-income persons below 200 percent of the federal poverty level is a priority of the department. Over the last several years, the department has funded initiatives to expand the infrastructure of county health department safety-net dental programs. The overall capacity continues to increase around 12 percent yearly. The majority of the people served through our programs are Medicaid-enrolled children, and during the past year we saw a 17 percent increase in the number of Medicaid dental recipients. A state oral health improvement plan for disadvantaged persons has been finalized through broad-based input to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors. The state plan development has been facilitated through the HRSA MCH-B Oral Health Collaborative Systems grant.

Through a 2008 grant from HRSA the Public Health Dental Program (PHDP) formed an Oral Healthcare Workforce Ad Hoc Committee to evaluate and strategically address the complex range of current and projected oral healthcare workforce concerns. The focus of the committee was to increase access to dental services by evaluating and addressing the complex range of oral health workforce concerns that impact Florida's ability to recruit or retain available practicing dental providers, especially for Florida's disadvantaged and underserved populations.

A HRSA Grant to States to Support Oral Health Workforce Activities was awarded to the PHDP in 2009. The focus of this grant is to improve the accessibility of the oral health workforce for underserved geographic areas. Funding is for improving the infrastructure of the PHDP by establishing three positions: an education and prevention specialist, a recruitment and retention coordinator, and a community water fluoridation specialist. In addition, the grant created a pool of funds to help county health departments (CHD) establish or expand dental facilities and services and funds to contract with the University of Florida College of Dentistry for a training program for dental providers in the care of very young children. These initiatives can only result in an increased number of EPSDT children receiving Medicaid dental services especially when you take into consideration the primary focus of the PHDP and the CHD dental clinics is the treatment of Medicaid children.

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	16.3	10.4	11.2	14.7	13.5
Numerator	11940	7745	8390	12307	12506
Denominator	73181	74488	74846	83719	92716
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

When a family, who meets the financial eligibility criteria for SSI, applies for benefits, the application is sent to the Office of Disability Determination Services for a medical eligibility decision. After a medical decision is made, the information about the child, whether eligible or not eligible for SSI benefits, is sent to the CMS Program Office. The CMS SSA/SSI Liaison reviews the information about the child. The information about the child is sent to the CMS office in the area where the child resides. An individual in the local CMS office contacts the child's family to find out if the child has a health care provider. If not, the family is invited to apply for services of CMS. When a child with mental illness applies for SSI benefits, the CMS SSA/SSI liaison sends the information about that child to the Children's Mental Health Program in the Department of Children and Families for follow-up.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of low birth weight (< 2,500 grams)	2008	matching data files	10.3	7.1	8.8

Narrative:

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL

<i>MCH populations in the State</i>					
Infant deaths per 1,000 live births	2007	matching data files	8.5	4.9	6.7

Narrative:

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2008	matching data files	69.6	89.5	79

Notes - 2011

Percent of infants born to women who began care in the first trimester differs from the values provided on Form 11 NPM #18 because births with unknown linking information are excluded.

Narrative:

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 <i>Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State</i>	YEAR	DATA SOURCE	POPULATION		
			MEDICAID	NON-MEDICAID	ALL
Percent of pregnant women with adequate prenatal care (observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2008	matching data files	53.9	69.6	61.2

Notes - 2011

Data for "all" column differ from numbers reported elsewhere in report, as this data comes from a different source. Source for this data looks at matched data files that exclude those without an

SSN number. In the case of multiple births, multiple births are counted as one delivery, further skewing the results. Data for this indicator is more accurately reflected on Form 17.

Narrative:

As expected, for all indicators on this form, the non-Medicaid population has considerably better outcome indicators than the Medicaid population. Please see form 18 for data.

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Infants (0 to 1)	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Infants (0 to 1)	2009	200

Narrative:

Infants 0-1 whose family income is 185 percent or below of the Federal Poverty level and below are covered by Medicaid. Infants 0-1 whose family income is between 185 percent and 200 percent of the Federal Poverty level are covered by SCHIP.

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2009	133 100
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Medicaid Children (Age range 1 to 6) (Age range 6 to 18) (Age range to)	2009	200 200

Narrative:

Children 1 to 6 whose family income is 133 percent of the Federal Poverty level or below are covered by Medicaid. Children 1 to 6 whose family income is between 134 percent and 200 percent of the federal poverty level are eligible for KidCare. Children 6 to 18 whose family income is 100 percent of the Federal Poverty level or below are covered by Medicaid. Children 6 to 18 whose family income is between 101 percent and 200 percent of the federal poverty level are eligible for KidCare.

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL Medicaid
Pregnant Women	2009	185
INDICATOR #06 The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.	YEAR	PERCENT OF POVERTY LEVEL SCHIP
Pregnant Women		

Notes - 2011

In Florida, pregnant women are not eligible for SCHIP coverage.

Narrative:

Pregnant women whose family income is 185 percent of the Federal Poverty level and below are covered by Medicaid.

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
<u>ANNUAL DATA LINKAGES</u> Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	1	No
<u>REGISTRIES AND SURVEYS</u> Hospital discharge survey for at least 90% of in-State discharges	2	Yes
Annual birth defects surveillance system	3	Yes
	3	Yes

Survey of recent mothers at least every two years (like PRAMS)		
--	--	--

Notes - 2011

Narrative:

Infant Death Certificates: This linkage has been accomplished and extended during the project period to include birth records linked to the following:

- Fetal and infant death records
- Healthy Start prenatal risk screening data
- Healthy Start infant risk screening data
- Healthy Start prenatal services
- Medicaid participation
- WIC participation
- Census Tract Information

The data has been made available to county health departments and Healthy Start coalitions for analysis of outcomes in their area.

Medicaid Eligibility or Paid Claims Files: The project that links maternal Medicaid eligibility files to birth certificates is an ongoing collaboration of the Florida Agency for Health Care Administration; the Office of Planning, Evaluation, and Data Analysis; the University of South Florida Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies; and the University of Florida's Maternal Child Health and Education Research and Data Center (MCHERDC). The actual linkage is completed by the MCHERDC and provides the information on Medicaid participation identified above. The project produces annually a Medicaid MCH Indicator Report. The University of Florida is also using this and other data to evaluate Florida's 1915(B) Healthy Start Medicaid Waiver.

WIC Eligibility Files: The maternal WIC eligibility files are linked to birth certificates as part of the Medicaid collaboration. This linkage provides the data listed under infant death certificates and is included in the annual Medicaid MCH Indicator report. The Department of Health is currently planning to evaluation the WIC linkage quality.

Newborn Screening Files: Newborn Screening data has been linked once to live birth certificates in 2004. This linkage identified that only a small percentage of live births are not receiving newborn screening. However, screening of every newborn is important. Plans are under development to integrate the data entry for live birth certificates and newborn screening at the delivery hospital to establish an ongoing process for identifying newborns who are not screened.

Hospital Discharge Survey Data: Ability to access to this data has been consistently available in recent years, but access can change over time. Once established for a user, is consistent. Direct access is limited to de-identified data without a special data sharing agreement. Other parts of the Department do have access to identified discharge data.

Birth Defects Registry: SSDI staff continues to work closely with Birth Defects Registry staff to develop further data linking and utilization strategies. Increased awareness of Birth Defects Registry availability and access was achieved through convening a meeting of local and regional public health leaders, lead by SSDI staff. Plans are underway to develop a birth defects research data files that will allow this data to be more readily analyzed by internal and external partners including SSDI staff.

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Florida Youth Tobacco Survey	3	No

Notes - 2011

Narrative:

There are two surveys in Florida that can be utilized to determine the percent of adolescents who smoke, the Youth Risk Behavior Survey (YRBS) and the Florida Youth Tobacco Survey. We can access the results of the surveys, but the MCH program does not have direct access to the survey databases for analysis.

IV. Priorities, Performance and Program Activities

A. Background and Overview

The Government Performance and Results Act (GPRA - Public Law 103-62) requires that each Federal agency establish performance measures that can be reported as part of the budgetary process that links funding decisions with performance and related outcome measures to see if there were improved outcomes for target populations. Priorities and state performance measures have been established based on needs assessment activities.

B. State Priorities

State priorities were determined through the five-year needs assessment. That process indicated a need to focus on reducing risk factors that adversely affect outcomes for the maternal and child health population. The priorities also reflect an increased focus on reducing racial disparities. Priorities were determined using both quantitative and qualitative data, as well as the recommendations of our needs assessment advisory committee. Following is a list of the eight state priorities for Florida, and the performance measures they relate to.

1. Prevent unintended and unwanted pregnancies.
SPM#2 (new) The percentage of births with inter pregnancy interval less than 18 months.
2. Promote preconception health screening and education.
SPM#3 (new) The percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy.
3. Promote safe and healthy infant sleep behaviors and environments.
SPM# 4 (new) The percentage of infants not bed sharing.
SPM# 5 (new) The percentage of infants back sleeping.
4. Prevent teen pregnancy.
NPM#8: The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
5. Improve dental care access, both preventative and treatment, for children.
NPM#9 Percent of third grade children who have received protective sealants on at least one permanent molar tooth.
SPM#7 (new) The percentage of low-income children under age 21 who access dental care.
6. Increase access to medical homes and primary care for all children, including children with special health care needs.
NPM#3 The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home.
7. Improve health care transition for adolescents and young adults with special health care needs to all aspects of adult life.
NPM#6 The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life.
8. Increase early intervention services for children with special health care needs.
SPM#1 The percentage of Part C eligible children receiving service.

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99	100	100	100	100
Annual Indicator	99.0	100.0	100.0	100.0	100.0
Numerator	222763	646	1173	1362	1289
Denominator	225013	646	1173	1362	1289
Data Source				Florida Newborn Screening Program	Newborn Screening Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	100	100	100	100	100

a. Last Year's Accomplishments

Florida statutes require that every newborn born in the state must be screened before one week of age. Although parents have the option of refusing the test, almost all babies are tested. It is estimated that less than 1 percent of parents refuse to have their newborns participate in the statewide screening program. This is a population-based service. All of the MCH population groups are served by this measure. Follow-up activities include contracts with genetic specialty centers for referral of patients with abnormal test results, and contracts with cystic fibrosis, endocrine and hematology/oncology specialty centers. Specialty referral centers arrange for confirmatory testing and treatment for patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.

In 2008, testing identified 1,362 babies with presumptive positive screening results. After confirmatory testing, 359 were found to have one of the 34 disorders. Of the 359 confirmed cases, all of them received timely follow-up and treatment. Final data for 2009 are not yet available.

Enabling services activities provided by the department include referral of patients with presumptive positive test results to genetic specialty centers, endocrine specialty centers, and hematology/oncology specialty centers. Specialty referral centers provide confirmatory testing and treatment to patients identified through the Florida Newborn Screening Program. Genetic counseling, follow-up, and nutritional counseling activities related to treatment and dietary management are included. Educational materials are distributed to all birthing facilities regarding the five disorders that are tested in the newborn metabolic screening. The previous two activities are population-based services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Florida contracts with three genetic specialty centers for referral of patients with abnormal PKU, Galactosemia, Biotinidase and other metabolic disorder test results.		X		
2. Florida contracts with three endocrine specialty centers for referral of patients with abnormal congenital hypothyroidism and congenital adrenal hyperplasia test results.		X		
3. Florida contracts with 10 hematology/oncology specialty centers for referral of patients with abnormal hemoglobinopathy test results.		X		
4. Florida contracts with 11 Cystic Fibrosis Centers for referral of patients with abnormal cystic fibrosis test results.			X	
5. Specialty referral centers arrange confirmatory testing and treatment to for patients identified through the screening program. Genetic counseling, follow-up and nutritional counseling activities (treatment and dietary management) are included.			X	
6. Educational materials are distributed to all birthing facilities regarding the 34 disorders that are tested in the newborn metabolic screening.			X	
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Newborn Screening Program expanded the number of disorders screened to 35 including hearing. Beginning on January 9, 2006, all babies born in Florida were screened for 28 of the 29 disorders recommended by the American College of Medical Genetics plus five more recommended by the 2002 Florida Infant Screening Task Force. Florida began screening for cystic fibrosis on September 17, 2007. Entities that submit specimens for testing are responsible for forwarding the lab results to the newborn's primary care physician to ensure that the medical home is informed of the results. Beginning December 2005, hearing screening results were included on the lab report. All newborns identified through the Newborn Screening Program are medically eligible for the Children's Medical Services Network Program. These are population-based services.

c. Plan for the Coming Year

Florida developed a Web-based Internet program for physicians to access for newborn screening results that became available in December 2008. The website will soon be open for hospitals to obtain the newborn screening results also. There are plans to link the electronic birth registration information with newborn screening in summer 2010. The data will be uploaded nightly to auto-populate the newborn screening demographic fields. This will ensure accurate data and also provide an accounting of each baby issued a birth certificate also receives a newborn screening test. CMS will continue to contract with specialty centers for appropriate referrals; provide genetic counseling, follow-up and nutritional counseling activities; and continue distributing educational materials to all birthing facilities.

Form 6, Number and Percentage of Newborns and Others Screened, Cases Confirmed, and Treated

The newborn screening data reported on Form 6 is provided to assist the reviewer analyze NPM01.

Total Births by Occurrence:	231658					
Reporting Year:	2008					
Type of Screening Tests:	(A) Receiving at least one Screen (1)		(B) No. of Presumptive Positive Screens	(C) No. Confirmed Cases (2)	(D) Needing Treatment that Received Treatment (3)	
	No.	%	No.	No.	No.	%
Phenylketonuria (Classical)	229342	99.0	34	6	6	100.0
Congenital Hypothyroidism (Classical)	229342	99.0	87	65	65	100.0
Galactosemia (Classical)	229342	99.0	74	7	7	100.0
Sickle Cell Disease	229342	99.0	272	192	192	100.0
Biotinidase Deficiency	229342	99.0	25	8	8	100.0
Congenital Adrenal Hyperplasia	229342	99.0	142	7	7	100.0
Cystic Fibrosis	229342	99.0	605	49	49	100.0
MS/MS disorders	229342	99.0	123	25	25	100.0

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	51	53	55	52	54
Annual Indicator	45.4	50.2	50.2	50.2	50.2
Numerator					
Denominator					
Data Source				Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average					

cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	53	55	57	59	61

Notes - 2009

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2008

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

The six CMS goals incorporate the key systems outcomes of the Maternal and Child Health Bureau. The first CMS goal states: "Children who are enrolled in CMS Programs and their families will be partners with CMS in decision-making at all levels and will be satisfied with the services they receive." Data collection for this infrastructure building service consists of:

Measure 1: Children and their families will have a positive perception of care.

A. Percent of families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.

B. Percent of Title XXI families reporting satisfaction with the quality of primary care, obtaining referrals, needed services, and coordination among providers.

C. Percent of complaints and grievances (# complaints/#eligible clients within the quarter).

D. Percent of families reporting satisfaction with CMS Area Office operations and staff (# positive response surveys/# surveys completed within the quarter).

Measure 2: Children and their families are partners with CMS in decision-making.

A. Percent of parents who report satisfaction with their level of involvement in setting concerns/priorities about their child's care.

In state fiscal year 2008-2009, 69 percent of parents rated the quality of care in the CMS Network program as excellent or very good. Statewide, on a scale of 0-3, parents gave family centered care-shared decision making an overall score of 2.76.

Satisfaction surveys for parents of children enrolled in CMS Programs were conducted through a CMS contract with the Institute for Child Health Policy (ICHP), University of Florida. During fiscal year 2008-2009 surveys, 91 percent of parents responded they were satisfied with CMSN benefits. A total of 78 percent of parents indicated their nurse care coordinator is knowledgeable and helpful.

The CMS Network (CMSN) contracted with Family Resource Coalition, Inc. (FRC) for family-centered care. The Family Resource Coalition contract included assignment of family health partners as FRC subcontractors in each CMS area office. The family health partners worked with the families of children enrolled in CMS to understand relevant issues and link them to available resources. FHPs also resolve conflicts, teach parents to navigate the system of care, and work in partnership with CMS staff and providers to ensure a family-centered environment in all CMS area offices.

CMS also began working with the Family Resource Coalition to start family advisory councils.

CMS started family advisory councils in three regions of the state.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Family-to-family support and contact will be facilitated throughout CMS	X			
2. CMS staff will produce and market materials that explain the CMS Mission, Vision, Goals and Services via their website, printed materials, and other forms of media and advertising.			X	
3. Include CMS families in developing policy, training, and in-service education.		X		
4. A statistically significant number of Satisfaction Surveys will be obtained from children, teens, and young adults enrolled in CMS Programs or their families regarding the services received through CMS or a CMS contracted provider.				X
5. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Institute for Child Health Policy continues to conduct satisfaction surveys, under contract, for the CMSN. Populations within CMS are identified for surveys to support internal and other performance improvement measures. Surveys are aimed at describing and quantifying satisfaction and health-related quality of life for children enrolled in CMSN.

In addition, CMS continues to collect data from each of the 22 area offices for this and the other five national performance measures.

The Family Resource Coalition ended their contract with CMSN effective January 1, 2010. CMS local area offices have continued to employ family support workers and family health partners. The family health partners and family support workers are parents of children with special health care needs and have a unique perspective and ability to help other parents in an advocacy and support role. Some of the family health partners and family support workers have assisted CMS with formation of family advisory groups. There are currently three active family advisory councils in different areas of Florida. The family advisory councils are providing CMS with valuable feedback about strengths of the CMS system and areas for improvement.

c. Plan for the Coming Year

The CMS Network will continue to collect data on performance measures from each of the 22 area offices and track performance.

CMS will continue to contract with the ICHP to conduct the CMS Satisfaction Surveys of the families of CMS Network enrollees to evaluate issues including access to health care and satisfaction with services. This activity allows CMS to gauge and ensure a high level of satisfaction from all of its customers.

The family health partners and family support workers will continue to assist CMS with family-centered care initiatives including development of family advisory councils, and cultural competency trainings for CMS staff. Family health partners and family support workers in each area office will continue to help families access appropriate community resources, and family-to-family advocacy and support groups.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	51	53	55	45	47
Annual Indicator	39.5	41.9	41.9	41.9	41.9
Numerator					
Denominator					
Data Source				Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	44	46	48	50	52

Notes - 2009

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2008

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03.

a. Last Year's Accomplishments

1. Medical Home Education and Training-Population-Based Services-CSHCN

CMS saw the expansion of medical home projects in 2008 after medical home mini-grants to the primary care offices in 2007. CMS continues to strive for excellence in its Medical Home Spread with continued education and oversight of current medical homes through a variety of strategies in Florida's communities. CMS collaborated with many community-based programs to provide a multi-level strategy for implementing the Medical Home concept. CMS was selected to participate in multiple national medical home learning collaboratives based in three CMS regions in Florida.

In Miami, CMS collaborated with the Epilepsy Foundation to facilitate enrollment in the primary care network. CMS also provided assistance to the Epilepsy Foundation to integrate information. CMS developed outreach programs to recruit primary care physicians and specialists in the communities surrounding the CMS offices and to educate physicians about the benefits of participating in a medical home. CMS Primary Care Programs have initiated home visits for medical home clients, expansion of research into private practices, and have placed CMS care coordinators in federally qualified health centers.

2. Medical Home Outreach-Population Based Services-CSHCN

CMS participated in the legislatively appointed Florida Health Care Transition Services Task Force for Youth and Young Adults with Disabilities to develop a report and recommendations: Ensuring Successful Transition from Pediatric to Adult Health Care. This task Force was formed in response to State Bill 988 which was a call to action in 2008 to assess the need for health care transition services, to develop strategies to ensure successful transition from pediatric to adult health care systems, and to identify existing and potential funding sources. CMS provides transition specialists in several regional offices and established a statewide Young Adult Advisory Board to help guide agency decision-making around transition. CMS saw the growth of their innovative transition program JaxHATS (Health and Transition Services). JaxHats provides a medical home to youth, ages 16-26 with chronic medical or developmental issues in north central Florida. CMS began revision of the care coordination guidelines, Quality Improvement Process, and began development of disease management guidelines and duties as well as any associated forms. CMS collaborated with University of Florida to begin development of Web-based training modules and evaluation criteria for care coordination and disease management.

3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

On October 7, 2008, the Child Welfare: Fostering Connections to Success and Increasing Adoptions Act of 2008 was signed into law. The bill requires each state to develop a comprehensive approach to caring for children in foster care. The bill requires the provision of a medical home for these children. The Department of Health, in response to this hosted a conference with Department of Children and Families to begin dialogue about what is required to implement an effective medical home. CMS hosted an initial meeting to begin planning the approaches in order to meet the intent of the Act. At these events, several issues have been identified that will be addressed, including: continuity of Medicaid eligibility, timeliness of comprehensive behavioral assessment, and continuity of a medical home. CMS also began discussion with AHCA for providing medical homes for Medicaid beneficiaries.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Demonstrate the importance of a medical home to the health and well being of children with special health care needs through data collection, satisfaction surveys, and performance measures.				X
2. Medical home interagency leadership and collaboration through Task Forces and Workgroups.				X
3. Health care transition services task force and formation of transition coalition.				X
4. Support initiatives in tele-health, and other innovative delivery systems, that are built on the CMS medical home.				X
5. Assist families to understand the uses of tele-health.		X		
6. Identify and recruit potential or approved providers to serve CMS children with special health care needs and their families			X	

with a focus on recruiting specialists and dental providers.				
7. Care coordination and disease management web-based training.				X
8. Collaborate with other state agencies and community partners to provide services to children with special healthcare needs, foster children, and Medicaid beneficiaries in a medical home.				X
9. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on family partnering and satisfaction with services.				X
10.				

b. Current Activities

1. Medical Home Education and Training-Population-Based Services-CSHCN

CMS finalized a proposal to seek interest in medical home demonstrations projects using practice improvement techniques, quality improvement, with a care coordination focus.

2. Medical Home Outreach-Population Based Services-CSHCN

The Florida Health Care Transition Services Task Force for Youth and Young Adults with Disabilities, CMS is addressing the recommendations and strategies released in the 2009 report and preparing for implementation of the action plan. A statewide transition consultant was appointed, and development of local transition coalitions. JaxHATS was selected and the first meeting was held in 2009. CMS is revising the Quality Improvement Process which includes performance measures focusing on transition and will begin piloting the process in CMS area offices in 2009.

3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

CMS participated in an interagency agreement signed by the DOH, Agency for Health Care Administration, Persons with Disabilities, and Juvenile Justice to participate in moving the service delivery system towards medical homes for Medicaid beneficiaries based on the NCQA's published set of standards for a patient centered medical home. This group was convened in 2009 with the purpose of addressing health care planning. AHCA has submitted a sizable demonstration grant proposal to the federal CMS that includes focusing on CMS medical home pilots.

c. Plan for the Coming Year

1. Medical Home Education and Training-Population-Based Services-CSHCN

In an effort to unify and standardize the term medical home and what it means to CMS and CMS families, the following activities are planned for the next year: Develop an accountable and comprehensive administrative claiming process and a comprehensive system of payment accuracy review for the CMS regions. Decision Support and Information Technology: Develop a comprehensive information system and determine the critical decision support functions and reports. Medical Services: Improve our clinical services through the development of clinic standards, the development of medical homes throughout the state, newborn screening expansion, and enhancement of the Early Steps Program.

CMS will finalize the terms of the agreement with the American Academy of Pediatrics for the medical home demonstration in 2010. CMS will continue to promote the statewide implementation of medical home and collaborate with organizations to educate key partners on the local, regional, and state levels. Promotion will include focusing on primary care practices, state and community partners, and parents who have CHSCN. Training will be provided by the

American Academy of Pediatrics Medical Home Advisory Council Staff and the implementation of the pilot medical home projects will begin in at least ten offices.

The existing 13 medical home projects continue to expand and are located in private practice and federally qualified health centers. CMS medical home projects will continue to expand and at least two additional medical home projects are planned for this year.

2. Medical Home Outreach-Population Based Services-CSHCN

JaxHATS Coalition will meet throughout the coming year and develop partnerships for strategic action to improve the health care transition service delivery system and increase collaboration among providers in Florida.

CMS will implement new performance measures in the area offices addressing transition through the revised Quality Improvement Process. Using the revised process, the CMS area offices will continue to gather data and compile reports that identify children at risk for and with special health care needs, utilize quality of care measures, and track health expenditures and costs of services.

3. Medical Home Community Supports-Infrastructure Building Services-CSHCN

CMS will continue to work toward the implementation of the joint effort between Children's Medical Services (CMS), the Department of Children and Families (DCF), Persons with Disabilities, and Juvenile Justice and their contract entities to ensure comprehensive health care that is managed and coordinated by a medical home provider for children in out-of-home care (foster care, relative placement, non-relative placement). CMS is developing an implementation plan.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	55	59	93	62	64
Annual Indicator	58	58	58	58	58
Numerator					
Denominator					
Data Source				Florida State Profile data for CSHCN survey	Florida State Profile data for CSHCN survey
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	60	62	64	66	68

Notes - 2009

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2008

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey.

a. Last Year's Accomplishments

The U.S. Department of Health and Human Services Health Resources and Services Administration estimates that 13.4 percent of Florida children have a special health care need (National Survey of Children with Special Health Care Needs Chartbook, 2005-06).

As of September 2009, the CMS Network for children with special health care needs provided coverage to 46,698 Title XIX-funded children and 30,097 Title XXI-funded unduplicated children. In addition, 6,415 children received "Safety Net" services, state-funded services designed to provide limited wraparound services to children ineligible for Title XIX or Title XXI coverage, or whose private health insurance coverage is insufficient to meet the child's needs. These numbers are unduplicated for the Federal Fiscal Year ending September 30, 2009.

The statutorily created Florida KidCare Coordinating Council, section 409.818(2)(b), Florida Statutes, includes a diverse membership that makes recommendations to the governor and the legislature to improve the implementation and operation of the Florida KidCare program. Some of the council recommendations from the January 2010 report include: restore and fund Florida KidCare community outreach and marketing, and fully fund the Florida KidCare Program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate and coordinate with Medicaid and KidCare offices to strengthen outreach and enrollment strategies.		X		
2. Identify children at risk for and with special health care needs.		X		
3. Utilize quality of care measures for children enrolled in CMS Programs.				X
4. Track health expenditures and costs of services.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida Healthy Kids Corporation continues support for community outreach campaigns targeting organizations whose memberships and clientele focus on families potentially eligible for Florida KidCare. Currently, 34 organizations are partnering with Florida KidCare.

As part of the federal CHIP reauthorization law, the U.S. Department of Health and Human Services awarded almost \$1 million to the University of South Florida Covering Kids and Families (CKF) Project to help find and enroll eligible children in Florida KidCare, and to promote retention,

with special emphasis on racial and ethnic minority groups whose children are more likely to be uninsured. The Florida Department of Health (DOH) works closely with CKF to support these critical efforts.

DOH also provides posters and maintains the Florida KidCare website. Staff provides information to families through Children's Medical Services, county public health departments, school health and Healthy Start programs.

The Agency for Health Care Administration (AHCA) works with the CKF project to build partnerships and create community-based coalitions to promote and sustain Florida KidCare. AHCA also includes promotional materials in its presentations.

The Department of Children and Families provides materials and information to their community partners and uses direct mail techniques to contact families who do not qualify for Medicaid to encourage them to apply for Florida KidCare for their children.

c. Plan for the Coming Year

The state is in the process of updating materials and activities designed to identify unmet service needs for children with special health care needs. In collaboration with other Florida KidCare partners, the Department of Health will continue to reach out to families with potentially eligible children and encourage them to apply for coverage. The Department will also continue efforts at the state and local level to help eligible children retain their health care coverage.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	71	73	75	87	88
Annual Indicator	69.4	85.9	85.9	85.9	85.9
Numerator					
Denominator					
Data Source				Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	89	90	91	93	95

Notes - 2009

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2008

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

a. Last Year's Accomplishments

During fiscal year 08-09 CMS contracted with the Family Resource Coalition to provide Family Health Partners (FHPs) in CMS area offices. FHPs act as community liaisons and provide information, resources, and community contacts for families of CYSHCN.

CMS area offices in various areas provided specialty services via telemedicine. The clinics included neurology, nutrition, and dermatology in the southeast Florida area. The University of Florida's Florida Initiative for Telemedicine and Education (FITE) Diabetes Project, under contract with CMSN, provided telemedicine clinics for children and youth with diabetes enrolled in the Daytona Beach CMS Area Office with a University of Florida endocrinologist. CMS also started a telemedicine clinic to provide endocrinology services for CMS enrollees in the Panama City area connecting to a pediatric endocrinologist in Tallahassee.

CMS implemented an online web-based provider application process to help decrease the time required for enrolling new providers. The on-line application process started during the summer of 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Establish and maintain CMS Programs that support all caregivers and partners.				X
2. Support children, teens, and young adults, and family leadership programs that identify families as leaders and potential leaders.			X	
3. Promote use of telemedicine.		X		
4. Support family organizations/initiatives as they engage families of children at risk for and with special health care needs in effective partnerships.			X	
5. Evaluate the potential benefit of telehealth and telemedicine services for CMS enrollees and their families.	X			
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on community-based service systems.				X
7. Provision of a Pharmacy Benefits Program to CMS enrollees.	X			
8.				
9.				
10.				

b. Current Activities

The CMS activities are to support: caregivers and partners; children, teens, and young adults, family leadership programs; family organizations and initiatives, and to promote the use of telemedicine. These activities provide direct health care, enabling, population-based, and infrastructure building services.

Family Support Workers are employed by CMS area offices and are parents of children with special health care needs, who are familiar with the local communities, parent support groups and systems of care. They advocate and connect families to local resources. Local family advisory councils are being developed. There are family advisory councils in Miami, Jacksonville, and Gainesville.

The CMSN provides telehealth services to assure access to specialty services in underserved areas of the state. Telehealth specialty care services include endocrinology/diabetes care, genetics, nutritional counseling, neurology, and dermatology. Over 95 percent of parents and CMS enrollees surveyed rate the telemedicine service received as excellent or good. Many parents report telehealth services allows for access to services and decrease wait times to see a specialist

The ICHP conducts annual satisfaction surveys from randomly selected parents of CMS enrollees. Results indicated that about 85 percent of the respondents had one person they thought of as their child's personal doctor or nurse.

c. Plan for the Coming Year

CMS will continue gathering quarterly data reports from CMS area offices to measure and analyze success with its six goals on a community, regional, and statewide basis as well as in comparison with national data. ICHP will continue to conduct telephonic satisfaction surveys for CMS.

Children's Medical Services local area offices will continue to employ Family Health Partners and/or Family Support Workers in all of the CMS area offices so that every CMS enrollee and their family will have access to family-to-family support as well as information about community resources. CMS will continue to develop and expand family advisory councils in the CMS offices. The family advisory councils provide valuable feedback about strengths in the system and areas for improvement.

CMS will continue to provide telemedicine specialty clinics via two-way interactive video teleconferencing. The telehealth program benefits CMS children and families by reducing travel time, costs, and inconvenience. Also access to specialty care is improved by reducing wait times. CMS is always looking for ways to expand telemedicine services as physician interest, resources, and opportunities arise.

CMS will continue to evaluate the web-based provider application process to increase CMS Network provider participation.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8	10	12	34	36
Annual Indicator	5.8	33.8	33.8	33.8	33.8
Numerator					
Denominator					

Data Source				Florida State Profile data for CSHCN survey.	Florida State Profile data for CSHCN survey.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	34	36	38	40	42

Notes - 2009

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2008

Data for 2008 comes from the 2005/2006 Florida State Profile data for CSHCN survey.

Notes - 2007

Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data.

a. Last Year's Accomplishments

The sixth CMS Goal states that "Beginning at age 12, all teens and young adults with special health care needs who are enrolled in the CMS Network and their families will receive the services needed to make transitions to all aspects of adult life, including adult health care, work, and independence." Measures and indicators for this goal are:

Measure 1: Teens and young adults will participate in the development and periodic review of their care coordination and transition plans.

Measure 2: Teens and young adults will receive transition services that are age appropriate.

CMS Network Care Coordinators coordinated and facilitated transition activities. CMS tracked the successful completion of transition activities for each enrollee through the electronic Child Assessment Plan (CAP) with quarterly data. In fiscal year 2008-2009 the statewide average for the CMS Performance Measure 1 was 59.5 percent, and the statewide average for CMS Performance Measure 2 was 56.2 percent.

Planning for the eventual transition of all teens and young adults with special health care needs to adult services, and coordinating and facilitating transition activities with each teen, were examples of providing services to increase the percentage of teens ready to transition to adulthood. CMS provides educational transition material to teens. Materials and resources are available in English and Spanish, and on the CMS website.

A new transition guide for youth and young adults age 18 and older was developed under contract with the Institute for Child Health Policy (ICHP) and is available both as hard copy and on the CMS transition website. ICHP also developed additional videos to educate youth and young adults about communication with their health care providers and making the most of

medical appointments.

A CMS Network representative attended meetings of local and state workgroups, consisting of young adults, state agency professionals (including Exceptional Student Education and Vocational Rehabilitation), and other stakeholders to discuss youth transition issues and challenges.

The Jacksonville Health and Transition Services (JaxHATS) program continues to provide health and related transition services in a five county area in northeast Florida to youth and young adults age 16 to 26 with special health care needs and disabilities. The program assisted with health care transition referrals to adult physicians, both primary care and specialists, and worked with other agencies, organizations, and post-secondary schools for successful youth transition to adult life.

Through a contract with CMS, the Institute for Child Health Policy also continued to maintain the web-based curriculum for professional development (<http://transition.mchtraining.net/>). The purpose and content of the training site provides information and best practices for implementing health care transition. The provider will update the website as needed to reflect changes in HCT-related federal and state legislation and policies as well as CMS program policies and priorities.

In 2008, the Florida Legislature appointed a 14 member Health Care Transition Task Force comprised of key agency representatives and stakeholders. Dr. Chiaro, the Children's Medical Services Deputy Secretary, chaired the task force, which also consisted of 35 workgroup members. The Task Force report entitled Ensuring Successful Transition from Pediatric to Adult Health Care was presented to the Governor on December 30, 2008. Once the task force completed its report and dissolved, the workgroup members continued with strategic plan development based on findings and recommendations in the legislative report.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Plan for the eventual transition of all teens and young adults with special health care needs to adult services.		X		
2. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.		X		
3. CMS Network Care Coordinators will coordinate and facilitate transition activities with each teen beginning at age 12, to meet their needs.				X
4. Participate in a collaborative partnership with community organizations and state agencies to support the New Freedom Initiative and the Healthy and Ready to Work Transition services and systems.			X	
5. Create and maintain a CMS Youth Advisory Board staffed by CMS enrollees who are between 12 to 21 years of age.				X
6. Data collection and analyses from each CMS area office for CMS Goals/Performance Measures on youth transition.				X
7.				
8.				
9.				
10.				

b. Current Activities

CMS participates in collaborative partnerships with community organizations and state agencies.

The FloridaHATS program is to implement many of the task force recommendations mandated by task force. CMS in collaboration with FloridaHATS activity developed regional transition coalitions in three pilot sites. The purpose of the regional health care transition coalitions is to support health care transition initiatives on a local level. Activities include working with local health planning councils to develop county-level data reports to provide information about youth and young adults, and secondary data sets for health condition, disability status, SSI enrollment, CMS enrollment, and other pertinent data. The local coalitions will provide education and training activities for both consumers and providers; and advocate for improved health care financing strategies and policies. The initial meetings for the coalitions began in January 2010, and meetings are planned through May 2010.

The pilot sites include Pensacola and surrounding rural counties, the Tampa Bay area, and Duval County. FloridaHATS program members developed the Strategic Planning Guide for Regional Coalitions as a guide for the coalitions to plan development of local systems of care. FloridaHATS information, activities, and program updates are available at: <http://www.floridahats.org>.

c. Plan for the Coming Year

CMS will continue work with the FloridaHATS program to implement strategies identified by the task force. The local CMS offices will participate in the development and evaluation of the regional health care transition coalitions in the pilot sites identified. Further coalitions may be developed as resources allow.

CMS will continue to collaborate with other Florida agencies, including: the Department of Education, the Division of Vocational Rehabilitation; the Florida Developmental Disabilities Council, the Agency for Persons with Disabilities; the Department of Children and Families, Mental Health; and other Florida stakeholders, the University of Florida, the University of Miami Mailman Center for Child Development, and the University of South Florida's School of Medicine to ensure that health is included in youth transition projects.

CMS is working with The Institute for Child Health Policy through the Youth Transition Initiative contract to provide a health care skills instructional website. The website contains videos that demonstrate ways for youth and young adults to perform health care related tasks. Website videos also portray approaches youth and young adults can use to communicate more effectively with their doctors and other health care providers.

Additionally, in collaboration with ICHP, CMS is developing additional interactive tools to help children and young adults learn how to perform specific tasks related to taking responsibility for their own health care needs.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	90	90	90	90	90

Annual Indicator	86.6	82.8	84.8	84.4	81.9
Numerator	183802	180541	191834	200168	195839
Denominator	212243	218045	226219	237166	239100
Data Source				DOH Survey of Immunization Two-Year-Old Children	DOH Survey of Immunization Two-Year-Old Children
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	90	90	90	90	90

Notes - 2009

Beginning in 2009, this rate includes the addition of varicella vaccine.

a. Last Year's Accomplishments

The following initiatives were designed to improve immunization coverage levels in 2-year-old children: the department's missed immunization opportunities policy; outreach clinics; linkages with WIC and CMS; community partnerships and immunization coalitions; coordination with Healthy Start and managed care organizations; promotion of the Standards for Pediatric Immunization Practices in the private sector; measurement of immunization coverage levels in public and private site reviews; outreach and increased enrollment in Medicaid and SCHIP; and continued implementation of the Vaccines for Children Program. Activities performed that impact this measure generally fall within the category of population-based services, offering disease prevention interventions to the entire population. Changes in immunization rates of 2-year-old children can be attributed to the following: immunization registry not fully implemented with all private health care providers and the partnership with WIC not fully implemented for 2008/09 in all county health departments.

During CY 2008, 84.4 percent of 2-year-olds received four diphtheria, tetanus, pertussis; three polio; and one measles, mumps, rubella, three Haemophilus Influenza B, and three hepatitis B immunizations. Florida SHOTS (statewide immunization registry) is functional in all 67 county health departments, for over 2,000 healthcare providers and includes over 50 data upload partners that uploaded 10 million records in 2007. The majority of school districts in Florida have schools that participate in the program.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Recommend all health care providers implement the				X

Standards for Pediatric Immunization Practices.				
2. Continue implementation of the registry (Florida Shots) in the private sector				X
3. Implement/Continue missed opportunities policy for public and private health care providers.			X	
4. Continue WIC/Immunization linkage.		X		
5. Statewide initiative to improve collaboration with public and private stakeholders/partners in order to increase immunization coverage levels in this target population.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In CY 2010, we continue activities to meet the goal of 90 percent of all 2-year-old children who are appropriately immunized with the complete series of four doses of diphtheria, tetanus, pertussis vaccine; three polio doses; one dose of measles/mumps/rubella vaccine, three doses of Haemophilus Influenza B vaccine, three doses of hepatitis B, and one dose of varicella/chickenpox vaccine (4-3-1-3-3-1 series). Specific activities include parent education; involvement of Healthy Start, immunization coalitions, and community partnerships; linkage with WIC, CMS and managed care organizations; identification of pockets of need for under-immunization; tracking immunizations in the health department; implementation of recall systems; public and private provider site reviews to assess coverage levels and promote the Standards of Pediatric Immunization Practices; increased enrollment of the registry in the private sector; continued implementation of the Vaccines for Children Program; and a statewide initiative to improve collaboration with stakeholders/partners to increase coverage levels in the target population. We are increasing the emphasis on immunizations with all stakeholders with an ultimate goal of surpassing 90 percent immunization coverage by 2010. County health departments have developed immunization plans to raise immunization rates in their area. They work with WIC, local medical societies, CMS, and others to develop then implement their plans.

c. Plan for the Coming Year

Our objective for CY 2011 is that 90 percent of 2-year-olds receive age-appropriate immunizations. Outreach, promotion, and surveillance of rates will be utilized to support efforts in the private sector. The department will continue to coordinate with Healthy Start coalitions to increase parent education about the importance of childhood immunizations and encourage local community partnerships. We will continue to recommend that all health care providers implement the Standards for Pediatric Immunization Practices, and continue expansion of the registry (Florida Shots) in the private sector (infrastructure-building activities). The department will continue an active partnership with coalitions and service agencies. We will continue to implement the missed opportunities policy for public and private health care providers (population-based) and continue the WIC and CMS/Immunization linkage (enabling). We will continue to implement the statewide initiative to improve collaboration with stakeholders/partners in order to increase coverage levels in this target population. The Bureau of Immunization manages six Racial, Ethnic and Diversity Immunization-focused grants (awarded through the Office of Minority Health) that focus on the elimination of racial and ethnic health disparities in Florida.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	22	21.5	21	20.5	20
Annual Indicator	21.8	23.0	22.6	20.4	17.6
Numerator	7590	8135	8119	7286	6261
Denominator	347795	353756	358622	357335	355066
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	17.5	17	16.5	16	15.5

a. Last Year's Accomplishments

Provisional data for 2009 indicates a birth rate of 20 per 1,000 for teens 15 to 17, which is the same as the annual performance objective of 20 per 1,000. Family planning, positive youth development education and comprehensive school health service projects share the responsibility of providing reproductive health care services to teens throughout the state. Family planning provided an array of services to teenagers beginning with preconception risk assessment, counseling, dispensing contraceptive methods when requested, screening for sexually transmitted disease, and pregnancy testing.

Florida statute authorizes the Department of Health to make comprehensive medical knowledge, assistance, and services relating to the planning of families and maternal health care available to citizens of childbearing age. The overall program goal is to improve the health of Florida's women and children by reducing unplanned pregnancies and promoting positive pregnancy outcomes. The program works to improve maternal and infant health; lower the incidence of unintended pregnancy, including teen pregnancy; reduce the incidence of abortion; and lower rates of sexually transmitted diseases, including HIV.

The Positive Youth Development Program is designed to enhance the skills and improve the health status of Florida's adolescents and young adults through opportunities and programs developed in collaboration with families, communities, schools and other public and private organizations throughout Florida. The Positive Youth Development Program provides a network of community-based support to help adolescents succeed as they move into adulthood by focusing on the "assets" of individual youth and their families. Sponsored programs will reinforce positive attitudes, healthy behaviors and activities, and reduce risk-taking behaviors, such as sexual activity, substance abuse, suicide and behaviors that increase risk of unintentional injury and chronic disease.

Along with services, the Abstinence Education Program, as part of the It's Great to Wait marketing and media campaign, sponsored a number of community outreach activities designed to increase public awareness about abstinence as the only 100 percent effective way to avoid teen pregnancy and sexually transmitted diseases. The media campaign consisted of enhancement of the interactive, hyper-media website at www.greattowait.com, and educator training classes held in major cities across the state, as well as radio, television and print

advertisement.

During the FY 2009 school year, 46 of the 67 county health departments provided Comprehensive School Health Services Programs in 388 schools, serving 275,912 students in high-risk communities with high teen birth rates. Comprehensive school health programs are designed to provide services that improve student health, reduce high-risk behaviors, and reduce teenage pregnancy. The birth rate for Comprehensive school health 6th -- 12th grade females (11 to 18) was 8.5 per 1,000. This is accomplished through maintenance of high levels of school nursing services, including nursing assessments, referral and case management; and health education classes and prevention interventions. These projects provided 2,545 pregnancy prevention interventions to 4,667 participants and 2,611 pregnancy prevention classes to 52,293 participants. Comprehensive school health programs also provided an additional 6,775 prevention interventions in general health and high-risk behaviors correlated with teen pregnancy to 12,324 participants, and 50,019 health education classes to 901,470 participants. Aftercare and support services coordinated with Healthy Start and school district Teenage Parent Programs, enabled 85.84 percent of parenting teens to return to school after giving birth.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Teen pregnancy prevention classes, and case management and aftercare for students who give birth in Comprehensive School Health Services Projects.		X		
2. Conducting abstinence-only education classes.		X		
3. Conducting statewide abstinence media campaign.			X	
4. Developing community and Department of Health program collaboration.				X
5. Promoting consumer involvement.		X		
6. Provision of confidential family planning counseling and education.	X			
7. Provision of confidential family planning comprehensive contraceptive services.	X			
8.				
9.				
10.				

b. Current Activities

Comprehensive family planning services are available statewide through county health departments and local contract providers. The department also collaborates with other state agencies to provide the Medicaid Family Planning Waiver. The waiver is designed to reduce infant mortality, unintended pregnancies, and repeat births to teens 15 to 19 by increasing the use of family planning services following a pregnancy.

The Positive Youth Development Program enhanced its marketing and media campaign this year with the production of a Web Based Automated Human Interaction (WAHI), www.teentruth.org. The WAHI technology produces web dialogues in which different segments are addressed in one medium, and both message delivery and data collection form a true two-way conversation with individual audience members. The goal is to host an interactive conversation with youth, parents, and community leaders to increase healthy decision making and decrease high risk behaviors.

Comprehensive School Health Services Projects continue to operate in 46 counties, providing pregnancy prevention classes, case management, and aftercare services that enable parenting youth to return to school and graduate. The projects coordinate activities with local county health

departments abstinence programs, school district health educators, Healthy Start programs, Healthy Families Florida home visitors, school district teenage parent programs, and case managers from the Department of Children and Families.

c. Plan for the Coming Year

Family planning, positive youth development education, and school health programs are critical components of the department's plan to reduce the birth rate for teens 15 to 17. County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum women about extended family planning services. These providers will have access to applications and information brochures to increase awareness and use of family planning services under the special Medicaid program. We anticipate a reduction in the number of subsequent births to teens who access and utilize family planning services.

The Positive Youth Development Program will continue to focus on the management of locally funded projects to deliver positive youth development education. In the coming year, the marketing and media campaign will continue to focus on the marketing of the WAHI, www.teentruth.org, and target the main population centers in Florida. Plans for the coming year also include submitting an application for the Teenage Pregnancy Prevention Funding out of the Office of Adolescent Health as well as submitting state applications for the Title V abstinence Education Funding that was reinstated in the Healthcare Reform Act and the newly created Personal Responsibility funding.

The Comprehensive School Health Services Projects will continue to provide pregnancy prevention classes, case management, and aftercare services that enable parenting students to return to school and graduate. These projects will continue to coordinate activities with local county health department abstinence programs, school district educators, county health department Healthy Start programs, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Family Services. Local county health departments will continue to facilitate access to services for youth, and continue to collaborate with other community agencies on teen pregnancy prevention in their communities. Programs within the department that serve youth will continue to develop strategies to reduce the rate of births to teens.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	25.6	37.5	39	34	39
Annual Indicator	37.3	37.5	34.8	37.1	39.7
Numerator	26504	27216	23984	27758	32008
Denominator	71092	72602	68873	74906	80563
Data Source				DOH Public Health Dental Program	DOH Public Health Dental Program
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	
	2010	2011	2012	2013	2014
Annual Performance Objective	40	40.5	41	41.5	42

a. Last Year's Accomplishments

The total number of children receiving sealants in county health departments in 2009 is estimated to be over 45,000, a 9 percent increase from 2008. Issues with the department's Health Management System have been corrected and the county health department sealant data appear to be accurate.

Presently, final 2009 data for this national indicator are not available. Until survey capabilities are developed, an estimate of the number of Medicaid-enrolled 8-year-olds that receive sealants on their permanent first molars is monitored as well as the number of children that receive sealants through county health department safety net programs. Medicaid estimates indicate a slightly increasing trend in the percent of Medicaid 8-year-olds that are receiving sealants on their permanent first molars, possibly a result of the economical downturn during the calendar year. No sealant data are available from private providers in Medicaid Reform and managed care organizations. No sealant data were available from the community health centers. Thus, the 39.7 percent indicator in 2009 may actually be underestimated.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Promote the development of school-based sealant programs.				X
2. Promote increased sealant utilization in county health department safety net programs.	X			
3. Develop and maintain sealant promotional material on Internet site.			X	
4. Promote the development of a surveillance system to capture sealant utilization data on permanent molars of third and ninth graders.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Public Health Dental Program continues to promote the development of school-based sealant programs and the early placement of sealants on permanent first and second molars in county health department programs. Links to sites to order sealant promotional material are available on the program's Internet site. A strategy contained in the state oral health improvement plan relates to increasing the number of children receiving sealants. A HRSA Grant to States to Support Oral Health Workforce Activities was awarded in 2009 through which an education and prevention specialist position was established. One of the initiatives being researched by this specialist is the development of school-based sealant programs, through the county health departments. Through the department's Reducing Oral Health Disparities initiative to support county health department infrastructure expansion and contractual services,

incremental progress will continue to expand sealant utilization to low-income and minority populations.

c. Plan for the Coming Year

The program will continue to promote the development of school-based sealant programs through the departmental quality improvement process and coordination with school systems. HRSA grant funding will be used to continue the process of implementing the State Oral Health Improvement Plan for Disadvantaged Persons and its recommendations and objectives. Also with other HRSA grant funding initiatives will continue for the improvement of infrastructure of the Public Health Dental Program by the establishment of an education and prevention specialist, a recruitment and retention coordinator, and a community water fluoridation specialist. Through the department's reducing oral health disparities initiative to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. As resources permit, we will continue to develop specific web-based materials to promote sealants for the Internet and for distribution as appropriate. Promotion of school-based sealant programs through the department's Reducing Oral Health Disparities initiative and HRSA grants will continue.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	3.5	3.8	3.6	3	2.9
Annual Indicator	4.2	3.1	3.2	1.9	1.8
Numerator	142	107	110	66	62
Denominator	3352639	3403203	3448267	3449949	3422458
Data Source				DOH Office of Vital Statistics.	DOH Office of Vital Statistics.
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	1.7	1.6	1.5	1.4	1.3

Notes - 2008

Provisional data for 2008 are incomplete.

a. Last Year's Accomplishments

Activities to reduce child deaths in motor vehicle crashes include evaluation of children with special health care needs to determine the appropriate child safety seat or restraint and provision of loaner special needs seats or restraints when necessary. The Department of Health (DOH), Office of Injury Prevention, received a Florida Department of Transportation grant that funded the Florida Special Needs Occupant Protection Program. This program has seven sites located in

children's hospitals in Orlando, Tampa, Miami, St. Petersburg, Gainesville, Ft. Myers, and Hollywood. The program staff evaluated children with special health care needs to determine the appropriate child safety seat or restraint, and provided loaner special needs seats or restraints when necessary.

The DOH Office of Injury Prevention is the lead agency for SAFE KIDS Florida, part of the SAFE KIDS Worldwide Campaign, a global effort to prevent injuries to children under age 15. A total of 82.5 percent of children under age 15 in Florida live in a county where Safe Kids 10 local coalitions and six state chapters are operating. Florida's Safe Kids chapters and coalitions were active in child passenger safety by distributing child safety seats and launching public awareness campaigns.

During the past year, DOH was able to meet its goal and staff is working to continue to reduce the rate of deaths to children, ages 14 and younger, caused by motor vehicle crashes. Activities during the reporting year included the activities listed above and below.

The motor vehicle crash data includes crashes that occur between automobiles and bicycles. The Office of Injury Prevention continued the Florida Bicycle Helmet Promotion Program through a Florida Department of Transportation grant. This program provided over 17,000 bicycle helmets to over 100 community partners who fit and distributed the helmets within their community. The single most effective safety device available to reduce head injury and death from bicycle crashes is a helmet. National estimates report that bicycle helmet use among child bicyclists ranges from 15 percent to 25 percent. Apart from the automobile, bicycles are tied to more childhood injuries than any other consumer product. Helmet use reduces the risk of bicycle-related death and injury and the severity of head injury when a crash occurs. Helmet use can reduce the risk of head injury by 85 percent and severe brain injury by 88 percent. If 85 percent of all child cyclists wore helmets every time they rode bikes for one year, the lifetime medical cost savings could total between \$134 million and \$174 million. (Source -- SAFE KIDS Worldwide 2007 Fact Sheet) This program is designed to increase the helmet usage among children in low income households, rural counties, and in counties that experience a high incidence of bicycle-related injuries and death.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Florida Special Needs Occupant Protection Program operated in seven children's hospitals in Florida.	X			
2. Evaluation of children with special health care needs to determine the appropriate child safety seat or restraint.	X			
3. Provided loaner special needs seats or restraints when necessary.	X			
4. Purchased 210 special needs child safety seats/restraints and 123 replacement parts to be used at the seven children's hospitals. (DOT GY 08-09)		X		
5. Through the local SAFE KIDS coalitions and state chapters, conducted numerous car seat check-up events on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.			X	
6. Purchased over 17,000 bicycle helmets that were provided to community partners who fit and distributed the helmets within their community (DOT GY 08-09).		X		
7.				
8.				

9.				
10.				

b. Current Activities

On January 14, 2009, the Florida Department of Transportation funded the Florida Special Needs Occupant Protection Program. The staff is working to expand to an additional children's hospital and is working on a new training curriculum. Through the 10 local SAFE KIDS coalitions and 6 state chapters, numerous car seat check-up events are conducted on an ongoing basis and during National Child Passenger Safety Week, National SAFE KIDS Week, and Buckle Up America Week.

Staff identified over 100 community partners for the Florida Bicycle Helmet Promotion Program, at least one in each of the 67 counties in Florida. Over 17,000 bicycle helmets were purchased and distributed to the over 100 community partners, who will fit and distribute the helmets within their community.

The Office of Injury Prevention concluded the 2004-2008 Florida Injury Prevention Strategic Plan; with 74 percent of its strategies implemented. The 2009-2013 Florida Injury Prevention Strategic Plan encourages evidence-based interventions to address motor vehicle injuries, a leading cause of death and injury among children in Florida. The Florida Injury Prevention Advisory Council, Strategic Plan Goal Team Leaders and Teams are an important part of Florida's plan implementation success. The Department of Health has over 80 injury prevention liaisons from the county health departments, Children's Medical Services offices, and central office staff.

c. Plan for the Coming Year

- The Office of Injury Prevention submitted a concept paper to the Florida Department of Transportation to continue the Florida Special Needs Occupant Protection Program for the 2009-2010 Grant Year.
- The Office of Injury Prevention staff will seek subject matter experts to review the new Special Needs Training curriculum.
- The Office of Injury Prevention intends to continue to function as the lead agency for SAFE KIDS Florida and to continue our work in the area of child passenger safety.
- Work will continue implementing the 2009-2013 Florida Injury Prevention Strategic Plan.
- A concept paper was submitted to the Florida Department of Transportation to continue the Florida Bicycle Helmet Promotion Program for the 2009-2010 Grant Year.
- The Office of Injury Prevention will continue activities listed above regarding evaluation of needs, provision of child safety seats or restraints, training, and public awareness activities.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		31.5	35.2	38	38.5
Annual Indicator	31.4	35	37.5		
Numerator					
Denominator					
Data Source				National Immunization Survey	
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	39	39.5	40	40.5	41

Notes - 2009

Data for 2009 are not yet available. The Department of Health does not track breastfeeding data in the general population. The department has previously reported survey data from Ross Laboratories. Prior to 2005, the Department reported Ross data for the percentage of mothers in Florida who were breastfeeding in the hospital. In 2005, the Department began reporting Ross data for the percentage of mothers who were breastfeeding their infants at six months of age. However, Ross Laboratories has now ceased to conduct their Infant Feeding survey so data is no longer from this source. The Department now uses data provided by the CDC based on the National Immunization Survey. The CDC data is based on children born in 2004 and interviewed through November 2008.

Notes - 2008

Data for 2008 are not yet available. The Department of Health does not track breastfeeding data in the general population. The department has previously reported survey data from Ross Laboratories. Prior to 2005, the Department reported Ross data for the percentage of mothers in Florida who were breastfeeding in the hospital. In 2005, the Department began reporting Ross data for the percentage of mothers who were breastfeeding their infants at six months of age. However, Ross Laboratories has now ceased to conduct their Infant Feeding survey so data is no longer from this source. The Department now uses data provided by the CDC based on the National Immunization Survey. The CDC data is based on children born in 2004 and interviewed through November 2008.

Notes - 2007

The Department of Health does not track breastfeeding data in the general population. Prior to 2005, the Department reported Ross data (collected from the annual Infant Feeding Survey conducted by Ross Laboratories) for the percentage of mothers in Florida who were breastfeeding in the hospital. Beginning with the data for 2005, the Department began reporting Ross data for the percentage of mothers who were breastfeeding their infants at six months of age. The data source changed in 2006 when Ross Laboratories ceased to conduct their annual Infant Feeding Survey. At this time, the Department began using data provided by the Centers for Disease Control (CDC) which is obtained from the National Immunization Survey. The CDC data presents breastfeeding information according to the year of the child's birth. The data reflected in the chart above under 2007 is still information collected on children born in 2004 and obtained in interviews conducted through December 2006.

a. Last Year's Accomplishments

The Department of Health provides breastfeeding promotion and support activities through a number of different programs including WIC and Healthy Start. Activities target both the population at large as well as to specific subsets of the population such as WIC or Healthy Start clients.

The Department of Health does not track breastfeeding data in the non-WIC population. Provisional data from CDC's National Immunization Survey, which tracks data by birth year, indicates 37.2 percent of all infants in Florida were being breastfed at six months of age who were born in 2006. Our WIC program tracks breastfeeding rates monthly and this data helps Florida assess the state's progress in improving breastfeeding rates during the year.

The WIC program coordinated activities with Healthy Start program staff to ensure Healthy Start care coordinators offered breastfeeding information, education, and support to pregnant women in-need. One of the Department of Health's state office buildings continues to provide a "mothers' place" room for breastfeeding staff to use for pumping or nursing.

WIC continues to participate in the USDA's breastfeeding peer counselor program. The Florida WIC Program is in its fifth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. Services have expanded in 15 counties to provide breastfeeding promotion and support above and beyond what the regular WIC grant could accomplish. From October 2008 to September 2009, 53,949 personal interactions and 5,841 group classes were provided.

The Florida WIC Program implemented the new national WIC food packages designed to encourage exclusive breastfeeding and encourage longer continuation of breastfeeding. The WIC program designed and distributed to local WIC agencies materials in support of the new breastfeeding food packages for use with clients and staff.

In April 2009, the WIC Program participated in and assisted the USDA and Every Mother, Inc., with the filming of the new national breastfeeding curriculum Grow and Glow at WFSU. This curriculum will be provided to all WIC programs across the nation for distribution to local WIC agencies for required staff training.

The Florida WIC program was instrumental in helping to establish a statewide, broad-based breastfeeding coalition and sponsors the monthly conference calls. The state WIC office purchased and distributed World Breastfeeding Week kits to the local WIC agencies for use in promoting World Breastfeeding Week 2009.

The Department of Health requires that each county health department establish and adopt a written policy that protects, promotes, and supports breastfeeding as the preferred, superior method of infant feeding. This policy encourages each county health department to have a comprehensive plan for breastfeeding promotion, protection, and support that includes a positive, breastfeeding-friendly clinic environment. The county health department should ensure that Maternal and Child Health Providers with whom it contracts include breastfeeding education and support services.

Breastfeeding education and support is one of the services offered through the Healthy Start program. Breastfeeding education and support includes at least one face-to-face contact, an assessment of current infant feeding status, counseling consistent with breastfeeding plan of care, and referrals to local breastfeeding support groups or other support sources. Services provide anticipatory guidance and support to encourage pregnant women to initiate breastfeeding, prevent problems and address barriers, increase the duration and exclusivity of breastfeeding, and enable postpartum women to overcome any perceived or actual breastfeeding problems.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Tracked "Infants Ever Breastfed" rates and "Infants Currently Breastfed" rates and the "Percentage of WIC Breastfeeding Women/Total Infants for WIC."		X		
2. Sponsored monthly telephone conference calls for statewide Florida Breastfeeding Coalition group to support coalition activities.			X	

3. Sponsored monthly telephone conference calls for statewide WIC breastfeeding coordinators to share breastfeeding promotion and support activities and ideas.		X		
4. Breastfeeding education and support offered through Healthy Start.			X	
5. Breastfeeding peer counselor programs now active in 16 WIC local agencies.		X		
6. Sponsored monthly telephone conference calls for peer counseling program administrators to share information and support.			X	
7. Posted all breastfeeding education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The web site is www.FloridaWIC.org .		X		
8. Posted all breastfeeding education materials on the web for other Florida residents to use as well as other state agencies to adopt and use. The web site is www.FloridaWIC.org .			X	
9.				
10.				

b. Current Activities

The WIC program will continue to provide breast pumps and breast pump kits, so more women have the equipment they need to breastfeed successfully when funding is available. The Bureau of WIC and Nutrition Services will continue to monitor breastfeeding rates and the percentage of women in the WIC program who breastfeed and efforts to improve data collection and evaluation are ongoing with the addition of the services of an epidemiologist. WIC holds monthly conference calls with breastfeeding coordinators and peer counseling program administrators to share successful promotion and support activities and ideas. WIC provides breastfeeding updates on the conference calls attended by county health department clinical staff, Healthy Start direct service providers and coalition staff, and Mom Care advisors. Also, breastfeeding is one of the training topics included in the maternal and child health training provided by the Infant, Maternal, and Reproductive Health Unit. A representative for the Department of Health has been appointed for the Florida Breastfeeding Coalition along with a representative from WIC program.

c. Plan for the Coming Year

For FY2010, WIC will focus on emphasizing strategies and activities that help WIC mothers to continue breastfeeding, a population with traditionally lower breastfeeding rates. WIC will distribute breastfeeding equipment and information, as funding is available. WIC will continue the monthly conference calls with breastfeeding staff in the coming year as well as our efforts to collect, link, and validate breastfeeding data and statistics; monitor breastfeeding rates; and evaluate breastfeeding outcomes. The Florida WIC program has received expanded funding from the USDA grant and will work towards establishing peer counseling programs throughout the state. The enhancement of currently established breastfeeding peer counselor programs with funding from the USDA grant will continue. Florida WIC will explore contracting with Every Mother, Inc. to provide the management section of the Loving Support Through Peer Counseling curriculum in the summer of 2010. Florida WIC will also explore the possibility of contracting with Every Mother, Inc. to provide the Loving Support Through Peer Counseling training curriculum for use in training peer counselors in local agencies in the fall/winter of 2010.

The WIC program and the Healthy Start program will continue to coordinate their efforts to see that more women and families receive the education and support they need to promote and support increased breastfeeding. The Healthy Start program has an opportunity to use grant money for breastfeeding peer counseling programs in selected counties. WIC staff will assist the Healthy Start program with this project. In addition, WIC will continue to monitor the impact of the new national food packages and policies in support of exclusive breastfeeding. WIC will continue

working with the Florida Breastfeeding Coalition on statewide breastfeeding activities. The Department of Health will continue to promote and support breastfeeding through both county health department policies and guidelines and through WIC and Healthy Start programs.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	99	99	99	99	99
Annual Indicator	95.1	94.3	94.9	95.5	95.2
Numerator	215160	223723	227005	220970	211564
Denominator	226219	237166	239120	231417	222346
Data Source				CMS Newborn Screening Data Base	CMS Newborn Screening Data Base
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	99	99	99	99	99

a. Last Year's Accomplishments

Section 383.145, Florida Statutes, mandates that all babies born in Florida have their hearing screened prior to hospital discharge or within the first 30 days of life. The program collects hearing results on all babies born in Florida through the metabolic specimen card and paper forms submitted to the State Laboratory and the Newborn Screening Program. Letters are sent to babies' physicians and the families whose babies refer on the hearing screen stressing the importance of the follow-up testing. Phone calls are made to families, physicians, and audiologists to facilitate the completion of the baby's hearing testing. By identifying infants with hearing loss within the first 30 days of life, intervention services can be implemented that should help minimize any speech and language delays that might result.

Hearing screening training curriculum was distributed to 90 percent of all birth hospitals in Florida. Videos and brochures continue to be provided to parents, hospitals, and physicians regarding the importance of universal newborn hearing screening. Technical assistance regarding universal newborn hearing screening training for hospital screening personnel began in July 2003 and continues. A symposium was offered in the fall of 2009 to share current information about newborn hearing screening with hospitals, providers, and parents. Educational programs were developed as needed for hospital screeners, physicians, and parents. Brochures, posters, magnets, and educational materials were developed and provided to hospitals and physicians in an effort to educate parents and professionals on newborn hearing screening.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribution of educational materials to obstetricians, pediatricians, family practitioners, midwives, parents, hospitals and early intervention providers regarding universal newborn hearing.		X		
2. Providing technical assistance to all Florida birth facilities hearing screening personnel regarding newborn hearing screening.				X
3. Reporting of hearing screen results on metabolic specimen cards submitted to the state laboratory.			X	
4. Running data system reports to provide statistical information regarding births and the number of babies that refer on the hearing screen.				X
5. Decrease the lost to follow up rate to less than 25 percent.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Data system enhancements that did not occur last year are underway that will improve reporting capabilities. Hearing screening training curriculum is being distributed to the remaining 10 percent of birth hospitals. Planning for the next symposium (now called the Florida Summit on Childhood Deafness) is underway. This summit will share current information about newborn hearing screening with hospitals, parents and providers. Technical assistance for hospital hearing screening personnel continues to be provided. Education materials are annually distributed to hospitals and OBGYNs.

c. Plan for the Coming Year

The data system enhancements will be implemented and tested. CMS will link the EHDI data system with the birth defects registry database. We will offer the Florida Summit on Childhood Deafness in 2010 or 2011 to share current information about newborn hearing screening with hospitals, parents, and providers. CMS will develop educational programs as needed for hospital screeners, physicians, and parents. We will continue to provide technical assistance for hospital hearing screening personnel, and continue to develop and provide brochures, posters, magnets, and educational materials to hospitals and physicians in an effort to educate parents and professionals on newborn hearing screening.

Performance Measure 13: *Percent of children without health insurance.***Tracking Performance Measures**

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	15	11.2	13.5	13.2	18.8
Annual Indicator	11.3	14.0	13.6	19.2	16.7
Numerator	504000	570343	548000	785000	676000
Denominator	4476152	4073879	4015955	4084000	4046000
Data Source				US Census	US Census

				2007 Estimates	2009 Estimates
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	16.5	16.3	16.1	15.9	15.7

a. Last Year's Accomplishments

The Department of Health (DOH) continued to work throughout the year with the University of South Florida's Covering Kids and Families (CKF) Project, the Agency for Health Care Administration (AHCA), Department of Children and Families (DCF), Florida Healthy Kids Corporation, and a variety of public and private organizations to promote enrollment and retention in the Florida KidCare children's health insurance program.

Much of the activity in 2008 focused on helping eligible families retain coverage due to the transition of the Florida KidCare third party administrator and Medicaid fiscal agent contracts at the same time. Special activities included monthly analyses to identify and re-enroll eligible children who lost coverage in error, additional outreach to eligible families, and the creation of special teams to identify and resolve systems issues that caused erroneous loss of coverage. The Florida KidCare partner agencies also undertook special outreach efforts targeted to newly uninsured children whose families lost private coverage due to job loss.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Ensure families are informed that they can apply for Medicaid using the KidCare application year-round.		X		
2. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.				X
3. Policy development and evaluation of effects of Florida KidCare program changes on Florida KidCare enrollment and child uninsurance.	X			
4. Statewide notification of KidCare open enrollment			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Florida KidCare partner agencies, Department of Health, Agency for Health Care Administration, Department of Children and Families, and the Florida Healthy Kids Corporation, collaborate with the University of South Florida's Covering Kids and Families (CKF) project and

other entities to reach out to families whose children could qualify for Florida KidCare.

Contained in the federal CHIPRA reauthorization bill are new options to encourage administrative simplification, enrollment growth and retention. In Florida, SB 918, enacted in 2009, streamlines prior administrative requirements. Some provisions include:

- Using electronic income verification before paper documents
- Reducing the nonpayment cancellation penalty from 60 to 30 days
- Providing good cause reasons for voluntary cancellation of private coverage

Simplified transitions from Medicaid to another Florida KidCare component helps eligible children retain coverage more easily. Outreach efforts were also funded through a federal grant awarded to the CKF project and two other Florida organizations totaling almost \$2 million to promote Florida KidCare enrollment and retention statewide.

c. Plan for the Coming Year

The 2009-10 Florida legislative session ends on April 30, 2010. While several bills related to the Florida KidCare program have been filed this session, at the time of this writing none have reached a Committee to be heard. It is unclear whether any bills will be heard before the legislative session adjourns.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		30.7	30.5	30.3	30
Annual Indicator	30.9	30.7	30.9	30.9	29.6
Numerator	34901	37114	41730	49822	53043
Denominator	112905	121062	135187	161088	178926
Data Source				Office of WIC and Nutrition Services	Office of WIC and Nutrition Services
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	29.4	29.2	29	28.8	28.6

a. Last Year's Accomplishments

Data for FY2009 indicate that 29.6 percent of children ages 2-5 who received WIC services had a BMI at or above the 85th percentile. This exceeded our goal of 30 percent. The FFY 2008 percentage was 30.9 percent,

The Florida Department of Health's Bureau of WIC and Nutrition Services conducted a number of

activities during FY2009 to continue to help reduce the number of children deemed overweight based on body mass index.

The major work effort was the preparation for implementation of the new WIC food package. The WIC foods had not changed significantly in over 30 years. Based on recommendations by the Institute of Medicine, the WIC food package underwent significant changes to align with the Dietary Guidelines for Americans, the Healthy People 2010 goals and objectives, and the recommendations by the American Academy of Pediatrics. The preparation efforts included materials development and training for staff, vendors and clients.

In preparation for the new requirements on milk, a campaign was initiated which educated clients that in October 2009, WIC policy would change to only allow 1% lowfat or fat free milk for women and children 2 and older. Materials developed included flyers, posters, and flipcharts all in English, Spanish and Haitian Creole.

Nutrition "kits" were also developed to promote the new food items and healthy nutrition with these messages- Eat more fruits and vegetables; lower saturated fat, increase whole grains and fiber; drink less sweetened beverages and juice; and babies are meant to breastfeed. Included as part of these kits were lesson plans, English, Spanish, and Haitian/Creole flyers and flipcharts, coloring sheets for children, and posters.

The bureau continued to work with the Florida Interagency Food and Nutrition Committee to develop joint nutrition initiatives. During 2009, the theme was Wake Up To Breakfast. A manual was developed to help local agencies and other providers encourage healthy breakfast. The manual can be located at www.fifnc.com.

The Florida WIC Program is in its sixth year of receiving a United States Department of Agriculture grant for a Breastfeeding Peer Counseling Program. This special grant allowed expanded breastfeeding promotion and support in 15 counties above and beyond what could be accomplished with the regular WIC grant. From October 2008 to September 2009, 53,949 personal interactions and 5,841 group classes were provided.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue to encourage local WIC agencies to use prevention of overweight as a major nutrition education focus in their nutrition education and breastfeeding promotion efforts.	X			
2. Continue to provide tools on healthy eating and physical activity for WIC families such as nutrition education materials, and nutrition education campaigns focusing on healthy nutrition.		X		
3. Continue to translate all campaign materials and nutrition education materials into Spanish, since the Hispanic population has the highest percentage of overweight children on WIC and Haitian Creole	X			
4. Provide data to local WIC agencies each quarter which tracks the percentage of 2-5 year old WIC children who are > 85th percentile in each county.		X		
5. Post all nutrition education campaign materials and nutrition education materials on the web for other Florida residents to use as well as other state agencies to adopt and use - www.FloridaWIC.org .				X
6.				

7.				
8.				
9.				
10.				

b. Current Activities

Efforts continue with the implementation of the new WIC food package, which began in October 2009. Significant staff, vendor, and client training took place and continues on an on-going basis.

A nutrition education kit on physical activity has been developed. Included with the kit is an original music CD produced by the Department of Health, called Give Me 5 A Day!, which encourages children and parents to dance along with the songs. The CD has been mass-produced and provided to each WIC family. Other materials include a lesson plan, and client materials in English, Spanish and Haitian Creole, including a flyer, poster, coloring sheet and teaching flipchart. Another kit will be developed in 2010 on the importance of eating breakfast.

The bureau continues to encourage local WIC agencies to select a nutrition education objective when preparing their nutrition education program plan for federal fiscal years 2009 and 2010 that relates to overweight and obesity prevention. Most local agencies continue to choose obesity-related objectives, and all of the agencies had a breastfeeding promotion and support initiative.

The bureau was asked to make recommendations to improve the nutrition section of the governor's website, <http://www.healthyfloridians.com/>. This is being done in conjunction with the Bureau of Child Nutrition. Included in our recommendation are website references for parents to use to help them improve the nutrition and physical activity of their children.

c. Plan for the Coming Year

The Bureau of WIC and Nutrition Services will continue to develop and distribute more nutrition education kits for the next year. We will continue to add new WIC foods that become available and meet the nutrition requirements of the program.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		10.3	10.2	8	7.9
Annual Indicator		8.3	8.4	8.6	8.6
Numerator					
Denominator					
Data Source				PRAMS	PRAMS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	7.8	7.7	7.6	7.5	7.4

Notes - 2009

Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data for 2008 were available thru PRAMS "Ponder." Florida PRAMS' answer rate was less than 70% in 2008. 2009 is not available yet. We used the same information for 2009 that we used in 2008. We used the same information for 2009 that we used in 2008. For the PRAMS data, the numerator and the denominator are weighted to be representative of the state. Objectives for 2004-2010 differ from the objectives in SPM #3, women who report tobacco use during pregnancy, as data come from different sources.

Notes - 2008

Since Florida's birth certificate does not ask about smoking during the third trimester, PRAMS data is used to determine performance on this indicator. Data for 2008 were available thru PRAMS "Ponder." Florida PRAMS' answer rate was less than 70% in 2008. 2009 is not available yet. We used for 2009 the same 2008 information.

Notes - 2007

Data for 2007 are not yet available.

a. Last Year's Accomplishments

Florida's 2009 PRAMS data is not yet available, so we cannot determine our progress on this goal since the last report. Behavioral Risk Factor Surveillance System data reveals that in 2007, 53.6 percent of women smokers tried to quit smoking.

The Florida Constitution requires the legislature to annually fund a comprehensive, statewide tobacco education and control program using tobacco settlement money. Some of the funds are directed towards reducing tobacco use among pregnant women through specialized cessation services, education, and media.

The Every Woman Florida Initiative is aimed at raising awareness about the importance and benefits of being healthy prior to pregnancy and focuses on promoting change at the individual, provider and system level. It includes a social marketing awareness campaign, the development of a website and addressing preconception health issues within a March of Dimes statewide, multidisciplinary workgroup. The website was introduced in April 2009 and serves as an information portal for health tips, assessment tools and printable education handouts on preconception health. A fact sheet on smoking can be obtained from the website which provides information on the risks of smoking while pregnant, the risks of second hand smoke, and where to get help to quit smoking.

The Area Health Education Center Network was awarded \$10 million dollars to train current and future health professionals and to expand tobacco cessation services into each of Florida's counties. During 2008-2009, the AHEC Network trained nearly 13,000 current and future health professionals in many healthcare disciplines and incorporated tobacco education curricula into health professionals training programs at over 40 colleges and universities. Tobacco cessation services were established in nearly 300 sites in partnership with community health centers, health departments, hospitals, private physician offices and worksites.

County health departments, Healthy Start coalitions and Department of Health staff monitored prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke.

The Florida Quitline answers calls 24 hours a day, 365 days a year, and counseling appointments are available seven days a week. Telephone counseling is available in English and Spanish. The proportion of pregnant callers has increased during this past year and varies by month from 3 percent to 11 percent. Pregnant tobacco users who are ready to quit can receive eight counseling sessions. Self-help materials are also provided by mail. If callers prefer face-to-face

counseling, they are referred to the Area Health Education Centers that provide smoking cessation services.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provision of guidelines directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring of prenatal smoking indicators by county health department and state health office staff.				X
3. Training and technical assistance on the Make Yours a Fresh Start Family program and ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking.				X
4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications.			X	
5. Monitoring of compliance with Healthy Start Standards and Guidelines standards for tobacco cessation.				X
6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking cessation and reduction of second hand smoke.				X
7. Educating public about dangers of smoking during pregnancy and about the QuitLine using mass media.			X	
8. Enhancing preconception identification of and interventions with smokers.				X
9.				
10.				

b. Current Activities

In February 2010, IMRH signed a memorandum of agreement with the Healthy Mothers, Healthy Babies coalition to promote text4baby, a free mobile information service designed to promote maternal and child health. Text4baby provides pregnant women and new moms with information to help them care for their health and give their babies the best possible start in life. Women sign up for the service by texting BABY (or BEBE for Spanish) to 511411. Beginning the day after they sign up, women will receive free text messages timed to their due date and continue one year after the birth of the baby. These messages focus on a variety of topics critical to maternal and child health including smoking cessation and second hand smoke. Messages also connect women to resources on smoking cessation.

County health departments, Healthy Start coalitions and Department of Health staff continue to monitor prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second-hand smoke. Training was provided on Motivational Interviewing techniques that could be used with women and their family members who smoke.

c. Plan for the Coming Year

During FY2011, we will continue to provide technical assistance and search for effective interventions for those who smoke. We will support training opportunities on Make Yours a Fresh

Start Family, ACOG's Smoking Cessation, and A Clinician's Guide to Helping Pregnant Women Quit Smoking, and promote other vehicles found to be effective. We will continue to monitor smoking cessation activities statewide, evaluate data showing the success of these activities and data on smoking rates in general, and provide technical assistance as indicated. We will also continue to maintain a list of tobacco cessation contacts for each county health department and Healthy Start coalition and provide the contacts with updates on tobacco cessation activities and resources.

Family Planning providers across the state screen their clients for the extent of tobacco use, and provide information on the Quitline, one-on-one counseling on smoking cessation, and referral for smoking cessation classes as resources allow or as indicated.

We will continue to encourage all health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use as well as the dangers of second-hand smoke. We will also continue to monitor compliance with the Healthy Start Standards and Guidelines for tobacco cessation.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures

[Secs 485 (2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	6.4	6.3	6.2	5.6	5.5
Annual Indicator	7.0	5.1	5.8	5.8	6.2
Numerator	82	61	70	71	75
Denominator	1177427	1197439	1215013	1219853	1203142
Data Source				DOH Vital Statistics	DOH Vital Statistics
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	6	5.8	5.6	5.4	5.2

a. Last Year's Accomplishments

Provisional data indicate that the suicide rate per 100,000 for youth 15-19 increased slightly from 5.8 in 2008 to 6.2 per 100,000 in 2009 (provisional).

During FY 2009, school nurses and social workers from the comprehensive school health services project schools continued to refer students for community-based mental health services. School health nurses and social workers also provided prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

Florida has taken significant steps toward preventing suicide. The Statewide Office of Suicide Prevention and the Suicide Prevention Coordinating Council established a centralized structure

necessary for integrating and coordinating the statewide effort, providing unified direction, and formulating strategies that can be implemented at both the state and local levels. In addition, the Office and Council have forged strong alliances with national suicide prevention organizations.

Success in suicide prevention depends heavily on empowerment at the local level. An infrastructure built on cooperation among federal, state, and community levels is essential for comprehensively combating this problem. Expansion of community efforts interconnected by a network of shared information, mutual support, and reinforcing activities serve as a first line of defense against suicide. Through these partnerships, Florida will be able to augment existing suicide prevention capabilities and promote collaborative action.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Suicide prevention small group prevention-interventions and health education classes in Comprehensive School Health Services Projects.		X		
2. Youth suicide prevention train-the-trainer workshops for gatekeepers.			X	
3. Coalition building by the Florida Suicide Prevention Taskforce.				X
4. Utilization of proven mental health/screening programs.			X	
5. Implementation research-based suicide prevention pilot projects.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2010, school nurses and social workers at comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Department of Health internal suicide prevention workgroup met quarterly and coordinates the department's contribution to the FSPCC.

It is expected that during FY2011, Florida's health, mental health, education and law enforcement professionals will work closely on strategies to identify youth at risk for suicide so they can receive appropriate prevention and intervention services.

c. Plan for the Coming Year

During FY 2011, school nurses and social workers from the comprehensive school health services project schools will continue to refer students for community-based mental health services. Staff will also provide prevention interventions and classes in mental health, suicide prevention, violence prevention, conflict resolution, alcohol prevention, and drug prevention.

The Florida Suicide Prevention Coordinating Council will continue to meet four times per year while planning and designing strategies to implement the Florida Suicide Prevention Strategy. Other initiatives planned are the eighth annual Suicide Prevention Day at the capitol and a

statewide Suicide Prevention Symposium, depending on budget and travel constraints.

The Department of Health's internal suicide prevention workgroup will meet quarterly and coordinates the department's contribution to the FSPCC.

It is expected that during FY2011, health, mental health, education, and law enforcement professionals will work together on strategies to identify youth at risk for suicide so they can receive appropriate prevention and intervention services.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	90	90	90	90	90
Annual Indicator	79.1	86.5	88.1	86.9	88.3
Numerator	2855	3105	3454	3365	3271
Denominator	3610	3589	3920	3874	3706
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	90	90	90	90	90

a. Last Year's Accomplishments

Infrastructure-building activities during the past year to increase the percentage of very low birth weight infants being born at a high-risk facility included: four of the Regional Perinatal Intensive Care Centers (RPICC) providing 11 high-risk obstetrical satellite clinics. RPICC staff at the 11 designated facilities provide a comprehensive high-risk obstetrical outpatient clinic; and RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for the high-risk obstetrical patients and appropriate placement for neonates in the Level III NICU. Enabling activities included the provision of yearly educational programs to the community health providers by RPICC staff. In addition, transportation was provided through a contract for RPICC eligible high risk pregnant women to a RPICC and for neonates requiring care at a Level III NICU. The populations served are high-risk pregnant women and low birth weight/sick infants.

During 2009, 88.2 percent of very low birth weight infants were delivered at high-risk facilities. Although the goal of 90 percent was not reached, there was an increase compared to the 86.9 percent rate reported for 2008.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Regional Perinatal Intensive Care Centers (RPICC) staff from four of the RPICCs provides 11 high-risk obstetrical satellite clinics	X			
2. RPICC staff at the 11 designated facilities provides a comprehensive high-risk obstetrical outpatient clinic.	X			
3. RPICC staff provides yearly educational programs to the community health providers.			X	
4. RPICCs are monitored annually by physicians and Children's Medical Services Central Office consultants to ensure the quality of care for high risk obstetrical patients and appropriate placement of neonates in the Level III NICU.				X
5. Transportation is provided through a contract for high risk obstetrical patients to facilities with Maternal Fetal Medicine physicians and for neonates requiring care at a Level III NICU.		X		
6. Identify hospitals that are inappropriately delivering low birth weight infants, to provide education and linkage to an appropriate facility for high risk mothers and infants.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The CMS goal is to ensure that high-risk obstetrical patients and very low birth weight newborns are delivered and receive care at appropriate level hospitals. The following types of public health services continue to be provided through the RPICCs and by the RPICCs' staff. Direct health care services are provided at the RPICCs (inpatient and outpatient) and through the 11 high-risk obstetrical clinics located at varying distances from the RPICCs. Enabling services are provided, including transportation for high-risk obstetrical patients to a RPICC facility with a maternal fetal medicine physician and for low birth weight neonates that require Level III NICU services. This service is provided by a contract with one of the RPICCs. Enabling services include an educational program offered by the RPICC staff to the community health providers. Annual quality assurance onsite or desk review monitoring of the RPICCs is performed to ensure that standards of care are being met.

c. Plan for the Coming Year

The goal for FY2011 is to ensure that 90 percent of very low birth weight infants are delivered at appropriate hospitals with NICU services. Plans include an increase in the number of RPICC high-risk obstetrical satellite clinics in the panhandle area of Florida in order to increase access of high-risk obstetrical services to more women. RPICC staff will continue to provide services at satellite clinics to decrease the number of low birth weight infants by providing easier access to high-risk obstetrical maternal care and education. CMS will continue to provide educational programs to community health providers. CMS will continue to monitor RPICCs to ensure appropriate placement of neonates in the Level III NICUs. Emergency transportation will be provided through a contract to relocate high risk obstetrical patients to a RPICC facility with a Maternal Fetal Medicine physician and to move low birth weight neonates requiring care at a Level III NICU. The CMS RPICC consultants will identify delivering facilities that inappropriately deliver very low birth weight neonates, and encourage the establishment of linkages necessary to transfer high-risk obstetrical women to appropriate delivering facilities.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	86.3	80	79	79.5	80
Annual Indicator	78.5	76.8	76.0	76.9	78.4
Numerator	158516	165076	165365	159426	154401
Denominator	201817	215035	217503	207324	197046
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	80.5	81	81.5	82	82.5

Notes - 2007

Starting in 2004 trimester prenatal care began to be calculated as the time elapsed from the date of the last menstrual period to the date of the first prenatal care visit. Prior to 2004 these data were obtained by direct question that noted the trimester the mother began prenatal care. Consequently these data are not comparable to data from prior years. Births with unknown information as to when prenatal care began are excluded from the denominator. Annual performance objectives have been lowered to accommodate the change in data collection.

a. Last Year's Accomplishments

Provisional data for 2009 indicate 78.4 percent of pregnant women received prenatal care in the first trimester. This rate was higher than the 76.9 percent reported in 2008, but still lower than the 2009 performance objective of 80 percent. We continue to experience an increase in the number of uninsured pregnant women and a decrease in providers of prenatal care across the state. There is also a disparity between non-Medicaid and Medicaid women and early access to care. The rate of first trimester entry into prenatal care in 2008 was 67 percent for Medicaid women compared to 91 percent for women with private insurance (Florida CHARTS).

We have encouraged county health departments (CHDs) to offer Presumptive Eligibility for Pregnant Women (PEPW) or Simplified Eligibility for Pregnant Women to assist women with early entry. Until a final determination is made, PEPW allows women to be temporarily eligible for prenatal care coverage by showing only proof of pregnancy and completing a limited application. One issue we are seeing around the state is that our private providers are reluctant to accept the PEPW client until final Medicaid approval, thus delaying entry into care.

We worked with Healthy Start coalitions statewide to ensure an adequate infrastructure for the provision of first trimester prenatal care and continuous care for all pregnant women. We continue to work with the coalitions to promote awareness among providers that Medicaid pays additional reimbursement to providers who screen clients for Healthy Start in the first trimester. We developed policies that promoted wellness among women of childbearing age and helped educate women on the importance of first trimester entry.

Performance Improvement visits to the CHDs helped staff identify barriers to first trimester

prenatal care, and allowed our staff to provide focused technical assistance and training to counties with first trimester entry levels below the state average. Healthy Start coalitions provided or facilitated a variety of enabling services, depending on local needs and resources, such as translation services, outreach, health education, family support, case management, and coordination with WIC and Medicaid. All of these services help women access early prenatal care. In some communities there are few resources or options for prenatal care, especially for women who are uninsured and do not qualify for Medicaid. In these communities, the coalitions may provide financial support for the provision of direct health care services (prenatal care), as this is the only way these services are available to some of the women at highest risk.

The MomCare program, implemented statewide in FY2002, facilitates Medicaid coverage for prenatal care. MomCare provides prenatal care choice counseling, helps women access health care services, assists in follow-up of missed prenatal care appointments, and promotes coordination between prenatal care providers and supportive services. MomCare sends a packet to all clients that includes information on the Family Planning Waiver. We continued to ensure the statewide process of presumptive and simplified Medicaid eligibility for pregnant women.

We piloted the Group CARE Prenatal Project in six CHDs from 2005-2007. The Group Prenatal Care model encourages women to take an active part in their prenatal care and empowers them through self-help and support activities. Community involvement is one of the main components that differentiate this model from existing group models. This link between the community and health has a particular importance for pregnant women and infants who are vulnerable to biological, psychosocial, social, and environmental events and circumstances that can influence health. Promotion and technical assistance for group models of care were offered to CHDs and Healthy Start coalitions.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies.			X	
2. Continue focusing special technical assistance for counties with first trimester entry levels below the state average, and develop and implement strategies to improve access to early prenatal care.				X
3. Continue to promote the use of preconception health guidelines in the county health departments.				X
4. Continue the MomCare program.		X		
5. Continue Presumptive Eligibility and Simplified Eligibility Medicaid application processes to expedite entry into prenatal care.		X		
6. Continue working through the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate.				X
7. Continue to provide technical assistance for alternative prenatal care delivery options like the Group CARE Prenatal Project throughout the state.		X		
8.				
9.				
10.				

b. Current Activities

We continue to work closely with the Healthy Start coalitions and the Department of Children and Families in addressing issues for women accessing Medicaid coverage for pregnancy, or accessing provider services once Medicaid has been approved.

We have implemented preconception health guidelines for the county health department clinics, Healthy Start programs, and with our family planning clinical staff. We continue to collaborate with the March of Dimes to promote preconception health and encourage women to access early prenatal care through the Every Woman Florida Initiative. With funding from the March of Dimes, the department created a statewide Preconception Health Advisory Council that is charged with identifying best practices and making recommendations related to preconception health promotion and service availability in Florida. A website was established to promote the importance of being healthy prior to pregnancy as well as raise awareness on the importance of early access to care.

A special analysis was undertaken by the department to explore the availability of prenatal care within the county health department system and to identify areas of obstetrical provider shortage. Currently, 21 out of the 67 county health departments in the state do not offer prenatal services. Some Florida counties have no obstetrical providers or hospitals that offer delivery services.

c. Plan for the Coming Year

The Department of Health will continue to work with the Department of Children and Families and the ACCESS community network on a campaign to educate providers who assist women in the Medicaid application process. Through MomCare, we continue to help pregnant women in obtaining prenatal appointments and following up on their medical care. We continue to encourage CHDs to provide presumptive eligibility for pregnant women, allowing immediate access to Medicaid services. We will continue to encourage providers outside of the CHD to use the Simplified Eligibility Medicaid application. This streamlined process requires no face-to-face contact, reducing some of the stigma barriers in accessing Medicaid insurance.

We will continue to work through Healthy Start coalitions to encourage providers to see patients during the first trimester of their pregnancies, and we will continue to partner with the Healthy Start coalitions to implement strategies to remove barriers and improve access to care as well as develop solutions for increasing the first trimester entry rate. We will also continue focusing efforts toward counties with first trimester entry levels below the state average for special technical assistance, and develop and implement strategies to improve access to early prenatal care. We will accomplish this through continued QM/PI visits to counties, as well as through working in collaboration with Healthy Start coalitions statewide.

The focus will be on areas that have access to care barriers and low continuation of prenatal care. The Every Woman Florida Preconception Health Council will identify opportunities to encourage women to be healthy and prepared for pregnancy, and identify activities that will decrease unplanned or mistimed pregnancies. The aim is to increase community awareness of the importance of prenatal care as well as assist women in developing a support network within their community.

D. State Performance Measures

State Performance Measure 1: *The percentage of Part C eligible children receiving service*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	98	98	98	98	98
Annual Indicator	96.0	95.0	93.1	93.1	93.8
Numerator	30813	30243	29776	30976	33471
Denominator	32082	31818	31990	33276	35685
Data Source				Early Steps Data System Annual Report.	Early Steps Data System Annual Report.
Is the Data Provisional or Final?				Final	Final
	2010	2011	2012	2013	2014
Annual Performance Objective	98	98	98	98	

a. Last Year's Accomplishments

Direct health care activities related to this measure include identifying, evaluating, and providing services to eligible infants and toddlers through contracts with 15 local Early Steps. Early Steps also provided enabling activities such as maintaining reduced caseload sizes; providing technical assistance and training to early intervention staff and providers; providing advocacy, training and support services for families; and coordinating with Medicaid and other agencies to access funding and support for the service delivery system. Population based services included providing ongoing outreach, public awareness, and education. Examples of infrastructure building activities included revision of Early Steps policies and guidance documents to ensure consistency with new requirements of the Individuals with Disabilities Education Act (IDEA) and state requirements, maintaining a centralized system for provider enrollment; collaborating with established systems for personnel development, especially with university Infant Toddler Developmental Specialist (ITDS) programs; maintaining the Early Steps Data System, and implementing quality assurance monitoring to assess performance and ensure compliance with federal regulations and state policy.

Preventing the incidence of disabilities for infants and children is a state priority. It addresses the continuing need to provide adequate screening, assessment, and services to ensure infants and children receive the services they need to help them lead more healthy lives.

In accordance with the 2004 reauthorization of the IDEA, Early Steps publicly reported on statewide and local Early Steps performance. A determination of each local Early Steps was made in accordance with the provisions of IDEA and to identify local Early Steps that meet requirements and those in need of some level of assistance or intervention to meet the requirements of IDEA.

Technical assistance from national and regional technical assistance sources was utilized to improve the state's performance on State Performance Plan (SPP) Indicator 1 (timely service delivery) and SPP Indicator 9 (timely identification and correction of noncompliance).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Evaluate current service delivery system to improve services for infants and toddlers with disabilities and their families.			X	
2. Provide ongoing outreach, public awareness and education.		X		
3. Identify, evaluate and provide services to eligible infants and	X			

toddlers through contracts with 15 regional programs.				
4. Maintain reduced service coordination caseload size at 1/65.		X		
5. Develop and implement state policy and standards for providing services in natural environments, and implement a centralized system for provider enrollment.				X
6. A Continuous Improvement system that includes Quality Assurance monitoring, identification of noncompliance, technical assistance to help local programs achieve and maintain compliance, and implementation of sanctions for systemic noncompliance.				X
7. Provide for an Early Steps Data System to maintain an electronic record of all children served and services provided.		X		
8. Provide advocacy, training and support services for families.				X
9. Coordinate with Medicaid, Insurance, Department of Education and other agencies to access funding and support for service delivery system.				X
10. Implement a child and family outcomes measurement system to determine the extent to which child and family outcomes are positively impacted by receipt of services through Early Steps.				X

b. Current Activities

Monitoring and Technical assistance is provided to local Early Steps (ES) to promote performance and to ensure services are provided in accordance with federal regulations and state policy. Local ES with identified noncompliance is required to develop a Continuous Improvement Plan to ensure compliance within one year. ES continues coordination with Medicaid, Insurance, the Department of Education, and other agencies. Training materials and instruction are provided to local ES staff. A system of child outcome measurement has been implemented to provide information on the extent to which enrollees demonstrate improved outcomes as a result of early intervention services. A survey is conducted each year to determine which families perceive that ES has helped their child and family.

Improving state performance on SPP Indicators is a state priority in Florida's use of American Reinvestment and Recovery Act (ARRA) funds. Funds are utilized for initiatives to promote retention and recruitment of early intervention providers, and development of training modules. ARRA funds are also targeted to improvements to the ES Data System to enhance tracking capabilities and to supplement public awareness activities to pediatricians and other health care professionals.

In accordance with federal requirements, an annual performance report was submitted on February 1, 2010, which includes actual target data for July 1, 2008 through June 30, 2009.

c. Plan for the Coming Year

Early Steps will continue to implement the infrastructure and improvement activities described in the Florida Part C State Performance Plan. Recruitment and retention of a highly qualified work force to meet the service needs of eligible children will be a focus.

State Performance Measure 2: *The percentage of subsequent births to teens age 15 to 19*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	15.2	15	15.2	15	18

Annual Indicator	16.2	16.5	18.4	18.3	18.7
Numerator	4493	4635	4729	4405	4089
Denominator	27816	28008	25688	24089	21884
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	17.8	17.4	17	16.7	

a. Last Year's Accomplishments

Activities to reduce subsequent births to teens consisted of individual and small-group pregnancy prevention interventions, case management, family planning counseling and education services, comprehensive contraceptive services, abstinence education, peer education and mentoring, and collaboration with programs that work to reduce subsequent teen pregnancy. Provisional data for 2009 indicates that 18.7 percent of youth ages 15 to 19 that had previously given birth had subsequent births. Beginning with 2007 data, the percentage of repeat births to teens is now determined by a nationally recognized methodology, so the objective (based on previous methodology) was not met.

The statewide family planning program provided services at 67 local county health departments and contract agencies to 251,567 youth (male and female), ages 15 to 19 during 2009, compared to 243,893 in 2008. The male project in Collier County was refunded along with awards to four additional counties, which included Baker, Bay, Duval and Orange counties.

Two new special initiative awards were funded in Hernando and Martin counties. These two special initiatives were for teen pregnancy prevention. County health departments in Broward, Collier and Washington counties continued to provide health education activities for adult and male teens with male project funds until June 30, 2009. In July 2009, the male projects in Broward and Washington counties ended.

The statewide family planning program urged all counties to participate in the National Day to Prevent Teen and Unplanned Pregnancy on May 6, 2009. The books Making the List: Understanding, Selecting, and Replicating Effective Teen Pregnancy Prevention Programs, and It's a Guy Thing: Boys, Young Men, and Teen Pregnancy Prevention, were provided to all county health departments for the family planning clinics.

The Title X Family Planning Program Office purchased and distributed 178 Safer Sex Contraceptive Method educational kits to the 178 county health department family planning clinics that provide family planning services. The purpose of the kits was to assist with contraceptive method counseling and education for women and men. Statewide family planning trainings entitled "Clinical Services for Males" and "Adolescent Clinical Services: A Shift in the Paradigm" were provided to staff statewide.

The Healthy Start program provided universal risk screening for pregnant women and their newborns to identify those at risk for poor birth, health, and developmental outcomes. Healthy Start staff provided clients with information on the various methods of birth control to assist them in making informed decisions concerning their preferred family planning method. Training for teen pregnancy prevention was provided statewide to Healthy Start coalitions and family planning staff.

Comprehensive School Health Services Projects in 46 counties, served 275,912 students in 388 schools. These programs provided pregnancy prevention, preconception education, and intervention services for pregnant and parenting teens. Services included individual and facilitated small group activities, case management, and care coordination to help students access support services, return to school after delivery, stay in school, learn to avoid subsequent

births, and ultimately graduate. Comprehensive School Health Services Project staff worked closely with Healthy Start care coordinators, Healthy Families Florida home visitors, school district teen parent programs, and case managers from the Department of Children and Families. Pregnancy prevention health education classes to teens reached 52,293 students, in a total of 2,611 classes. There were a total of 77,261 female students in grades 6-12, and 657 of those students (8.50 per 1,000) gave birth. Of the 657 students who gave birth, 564 (85.84 percent) returned to school after giving birth.

The Medicaid Family Planning Waiver Program had an impact on subsequent birth rates and costs to the Medicaid program for teens that chose to utilize family planning services. The family planning office provided technical assistance to the counties and offered a statewide Title X family planning Medicaid waiver conference call training, in an effort to increase the numbers of participating clients. The family planning Medicaid waiver demonstration program ended November 30, 2009, but was extended through December 31, 2009.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Individual and small group pregnancy prevention interventions in Comprehensive School Health Services Projects and Healthy Start Programs	X			
2. School Health case management and care coordination in Comprehensive School Health Projects to enable parenting students to remain in school and graduate.		X		
3. Provision of confidential family planning counseling, education and comprehensive contraceptive services.	X			
4. Collaboration of Department of Health programs working to reduce subsequent teen pregnancy.			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The family planning program provides services to teens in all 67 counties in 178 clinics. Four special initiatives are specific for reducing teen pregnancies, and one of the four, in Collier County is for teen mothers and their children. The Collier County Special Initiative has been very successful having only one repeat teen birth since the program's inception in 2006. Additional successes of this program included 87 percent of participants completing high school or actively pursuing educational goals.

Webinars for "Contraceptive Update" and "Prevention of Sexual Coercion of Adolescents" are scheduled statewide for family planning staff in 2010. Four all day trainings including "Caring for Adolescent Clients," "Male Friendly Clinic" and "Contraceptive Technology and Current Reproductive Health Issues" are scheduled for 2010.

The county health departments were urged to participate in the National Day to Prevent Teen and Unplanned Pregnancy Campaign on May 5, 2010.

The Comprehensive School Health Services Project continues to provide services for pregnancy prevention, case management, and care coordination to prevent subsequent births to parenting

students. To accomplish this, Comprehensive School Health Services Project staff work closely with multiple agencies including school district teen parent programs, abstinence programs, teen counselors, and case managers from the Department of Children and Families.

c. Plan for the Coming Year

Florida's plan to reduce subsequent births to teens age 15 to 19 includes the provision of family planning services in all 67 counties, including pregnancy prevention counseling and contraceptive services, comprehensive reproductive health education, Healthy Start services, abstinence education, and school health services. County health departments were awarded \$459,905 for two Title X family planning special initiatives and five male projects in 2009. These will address unique local challenges in the areas of teen pregnancy prevention and male involvement. County health departments, Healthy Start coalitions, and agencies and programs involved in welfare reform will continue to educate and collaborate with other community agencies in reducing subsequent teen births. We require that counties with repeat birth rates higher than the state average create an action plan to address the problem. The family planning program office has plans to purchase educational materials about teen pregnancy prevention for all of the county health departments' 178 family planning clinics. The educational materials include informational postcards for parents of Latino youth, brochures for teens, booklets for local African-American and Latino faith communities, and booklets about positive youth development.

The Comprehensive School Health Services Projects will continue to provide services targeting pregnancy prevention, case management, and care coordination to prevent subsequent births to parenting students. These services will be coordinated closely with all programs and agencies. Collaboration will continue among department programs working with teens through the sharing of information and resources. Strategic planning efforts regarding teen pregnancy prevention and intervention will continue to be a top priority.

County health departments, local contract providers, Healthy Start programs, Healthy Families Florida programs, and other agencies that provide maternal and infant care services will inform postpartum teens about extended family planning services available through the Medicaid family planning waiver services. These providers will have access to client informational brochures to distribute to youth to increase awareness and use of family planning services with the special family planning Medicaid waiver program. Education and reduction in the number of subsequent births for teens are two goals of the programs. Increased numbers of teens accessing services is highly desired. If the youth is not eligible to participate in the family planning Medicaid waiver program, family planning services can be provided using the department's Title X family planning program.

State Performance Measure 3: *The percentage of women reporting tobacco use during pregnancy*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	8	9.5	7.5	6.9	6.8
Annual Indicator	8.0	7.6	7.1	6.9	6.9
Numerator	17719	17915	16884	15656	15002
Denominator	221731	237142	238830	227574	217350
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Is the Data Provisional or				Final	Provisional

Final?					
	2010	2011	2012	2013	2014
Annual Performance Objective	6.7	6.6	6.5	6.4	

a. Last Year's Accomplishments

In 2008, 6.9 percent of pregnant women reported tobacco use during pregnancy, compared to 7.2 percent in 2007. Final data for 2009 is not available. Thanks to Florida voters, the Florida Constitution now requires the Legislature to annually fund a comprehensive, statewide tobacco education and control program using tobacco settlement money. In May 2007, the Governor signed a bill specifying how this money will be spent. Some of the funds are directed towards reducing tobacco use among pregnant women through specialized cessation services, education, and media.

Last year, our ongoing activities continued. Pregnant women who smoke were identified in a variety of ways including the Healthy Start prenatal risk screen that asks if the woman smoked in the last two months. Smokers and their families are eligible for Healthy Start smoking cessation services. During 2008, 12,258 women received smoking cessation services, increasing to 13,931 in 2009. Smoking cessation services are also available for families of infants with a smoker in the home. In FY2008, a total of 5,082 families received these services, increasing to 5,513 in 2009.

The Infant, Maternal, and Reproductive Health Unit (IMRH) forwarded information on prenatal tobacco cessation and secondhand smoke to providers and home visitors through onsite training, teleconferences, conference calls, site visits, meetings, and email. IMRH maintains an Alcohol, Tobacco, and Other Drugs webpage on the DOH Internet site. IMRH developed a tobacco handout that is included in the Every Woman, Every Time preconception materials. The handouts are available online for downloading.

County health departments (CHDs), Healthy Start Coalitions (HSCs) and DOH staff monitored prenatal smoking indicators and compliance with guidelines on counseling all pregnant women and women of childbearing age on the dangers of tobacco use and second hand smoke. Staff provided technical assistance when indicated. Monitoring occurred through data review, HSC monitoring, review of coalition service delivery plans and annual action reports, and through CHD monitoring visits. We provided technical assistance during these visits, as requested, or when data indicated a need.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Providing guidelines and contract language directing health care providers to counsel women of childbearing age and all pregnant women on the dangers of tobacco use.				X
2. Monitoring prenatal smoking indicators by county health department, Healthy Start coalition, and state health office staff, with development of corrective action plans when indicated.				X
3. Training and providing technical assistance on the Make Yours a Fresh Start Family program and ACOG's Smoking Cessation During Pregnancy: A Clinician's Guide to helping Pregnant Women Quit Smoking, and other prenatal smoking cessation models.			X	
4. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications			X	

5. Forwarding information on tobacco cessation and secondhand smoke through conference calls, site visits, meetings, and email communications				X
6. Promoting partnerships with public and private sector prenatal care providers to increase access to smoking cessation services and implement programs and policies supportive of prenatal smoking cessation and reduction of second hand smoke.				X
7. Using mass media, educate the public about dangers of smoking during pregnancy and about the QuitLine.			X	
8. Enhancing preconception identification of and interventions with smokers.				X
9.				
10.				

b. Current Activities

Current activities to reduce smoking include most of the activities described above and current activities described under NPM #15. DOH staff continues to monitor prenatal smoking indicators, compliance with guidelines on counseling all pregnant women and women of childbearing age on tobacco use and secondhand smoke, and provide technical assistance when indicated.

A brochure was developed on Children and Secondhand Smoke that describes the risks to children who are exposed to secondhand smoke and suggests ways to reduce the health risks. This brochure and a number of other resources can be downloaded from the Florida Area Health Education network website.

The Florida AHEC network offers tobacco continuing education programs to health professionals through a variety of techniques and formats. In keeping with the Public Health Service Treating Tobacco use and Dependence: Clinical Practice Guideline -- 2008 Update, the network is effecting system change by imparting to health care professionals skills to treat tobacco dependence. Continuing education topics include brief intervention training, motivational interviewing, new tobacco products, cessation techniques, pharmacotherapy, pediatric pulmonary issues related to secondhand smoke, and best practices for working with special populations. These trainings are available to health professionals at low or no cost, provided through in-person workshops, seminars, and conferences as well as through DVD, CD-ROM and Internet.

c. Plan for the Coming Year

The department will continue to focus on reducing tobacco use in all populations, and particularly in women who are pregnant or intend to become pregnant. Activities listed above will continue during FY2010, and we will continue to provide technical assistance and search for effective interventions for those who smoke. We will also continue to maintain a list of tobacco cessation contacts for each CHD and Healthy Start coalition, and expand linkages with other private and public prenatal care resources and provide the contacts with updates on tobacco cessation activities and resources. Bimonthly conference calls with Healthy Start coalitions and county health departments include information on effective smoking cessation counseling techniques, the association between smoking and depression, and the increased risk of sudden unexpected infant death for infants exposed to tobacco smoke during both the prenatal and postnatal period.

State Performance Measure 4: *The percentage of low-income children who access dental care*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	22.5	22.8	24.3	23.8	26.7
Annual Indicator	23.5	22.9	26.3	29.5	
Numerator	478086	472330	550552	617240	
Denominator	2031717	2063891	2092910	2092022	
Data Source				DOH Public Health Dental Program	
Is the Data Provisional or Final?				Final	
	2010	2011	2012	2013	2014
Annual Performance Objective	26.9	27.1	27.3	27.5	

Notes - 2009

Data for 2009 are not yet available. Most of the data comes from Medicaid paid claims and CHC but will not be available until late summer/early fall 2010

a. Last Year's Accomplishments

The increase in access to dental care for children below 200 percent of the federal poverty level has shown a small increasing trend from 2003 to 2008, although there was a slight decrease in 2006. The 2006 decrease was partially due to the difficulty in getting data under Medicaid reform and capitated programs, Healthy Kids, and volunteer programs. Most of that difficulty with data has been rectified with improved data sources resulting in significant increases with the Healthy Kids program. The number of children county health department dental programs reached increased by 17 percent over the previous year, reaching over 150,000 children. This increase resulted from both increased capacity and improved performance.

Recommendations of the state oral health improvement plan for disadvantaged persons, facilitated by a HRSA Targeted Oral Health Services System grant, are ongoing. This broad-based initiative has the potential to increase awareness of oral health issues, collaboration, and partnerships, and to facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.

Currently, 78 percent of the population in Florida are on community water systems that receive the benefits of fluoridation. Long-term benefits will impact access through reduced treatment needs resulting in increased access through existing providers.

County health department program guidelines continue to facilitate quality improvement activities, an orientation and guidance resource for newly hired dental directors, and a foundation for technical assistance inquiries.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Facilitate the continued development of an integrated, coordinated oral health system between the public and private sectors.				X
2. Conduct community based dental projects.	X			
3. Promote increased access through county health department safety net programs.	X			
4. Promote the integration of oral health education in WIC, Child				X

Nutrition and other county health department programs, as appropriate.				
5. Promote the start of oral health practices in infancy and appropriate use of fluoride products throughout early childhood in conjunction with CDC's campaign, "Brush Up on Healthy Teeth."			X	
6. Promote the development of community and school-based preventive and educational programs.			X	
7. Update Internet site to facilitate information exchange				X
8.				
9.				
10.				

b. Current Activities

State oral health improvement plan activities continue. State forums to develop specific objectives and to increase awareness of the needs of specific population groups are currently underway. Through a HRSA Grant to States to Support Oral Health Workforce Activities, a pool of funds is created to help county health departments establish or expand dental facilities and services and to contract with the University of Florida, College of Dentistry for a training program for dental providers in the care of very young children. The integration of oral health into all appropriate DOH programs through the development of protocols and implementation activities at the county level will continue to receive emphasis, but this has been progressing slowly.

Due to budget cuts, quality improvement activities were curtailed most of the year, but recently a quality improvement coordinator was hired. Therefore, the promotion of increased capacity through county health department programs and increased quality improvement activities will continue. Statewide assessments of county health department guidelines and records will continue and a schedule will be promulgated for onsite QI visits, conference calls, and technical assistance.

Promotional activities to increase fluoridation will continue.

c. Plan for the Coming Year

Ongoing FY 2010 activities will continue. Through the department's Reducing Oral Health Disparities initiative and the Workforce grants to support county health department infrastructure expansion, incremental progress will continue to expand access to low-income and minority populations. The program will continue to advocate for an outcome-based surveillance system that is vitally needed to increase public awareness and to monitor the impact of activities on the improvement in oral health status. The basic screening survey component of the county health department health maintenance system, when implemented, will be used to analyze the oral health status of patients receiving care in county health departments.

State Performance Measure 5: *The percentage of pregnant women screened by Healthy Start*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	62	68	69	70	71.5
Annual Indicator	67.5	65.3	67.4	73.8	80.1
Numerator	152666	154808	161206	170787	176425

Denominator	226178	237142	239120	231417	220206
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	72	72.5	73	73.5	

a. Last Year's Accomplishments

During 2009, 80.1 percent of pregnant women were screened by Healthy Start (provisional), an increase from the 2008 rate of 73.8 percent. Florida statutes require providers to offer Healthy Start prenatal risk screening to all pregnant women. The screen identifies environmental, social, psychosocial, and medical risk factors that make a woman more likely to experience preterm delivery or delivery of a low birth weight baby. Depending on need and available resources, Healthy Start provides services to address identified risk factors.

In June 2008, the department completed and fully implemented the revised prenatal risk screen. One of the main goals of the revision process was to develop screening criteria that would be more accurate in identifying pregnant women at increased risk of poor birth outcomes. An analysis was conducted in 2009 to compare the performance of the revised 2008 prenatal risk screening criteria to the previous 1994 prenatal risk screening criteria.

The conclusion was that the revised 2008 Healthy Start Prenatal Screen criteria implemented in July 2008 was an improvement over the 1994 screening criteria in terms of identifying pregnant women at increased risk of delivering a low birth weight or preterm infant. The percentage of women classified as at-risk, or positive, as assessed by use of the screening instrument was essentially the same for both the 1994 and the 2008 prenatal screen criteria, but the sensitivity of the 2008 screening criteria for low birth weight and preterm labor was substantially higher for the new 2008 screening criteria compared to the 1994 screening criteria.

The Department of Health continued to provide ongoing training to the county health department and Healthy Start coalition staff regarding the revision. Additionally, the department maintained an online self-paced training module for the prenatal Healthy Start screening component in the Health Management System (HMS), which is used by new staff and seasoned staff alike. HMS is the local county health department data system that is used to input information from the screening forms, that is then uploaded to the state central registry for reporting purposes. The department updated the relevant Healthy Start Standards and Guidelines chapters that were impacted by the prenatal risk screen revision. Updates to the HMS related to the revised prenatal risk screen were also completed and implemented.

The department continued to hold bimonthly conference calls with the community liaisons that conduct community outreach activities and provide education to prenatal health care providers on the benefits of the Healthy Start program. In November 2009, community liaisons assumed facilitation of the calls on a rotating basis to encourage ownership of the activities. Liaisons also promote the importance of offering each patient the risk screen in a manner that encourages consent. The community liaison conference calls involve Healthy Start screening data updates, information and strategy sharing, training, technical assistance, and discussion regarding successes and challenges faced while conducting promotion activities.

During 2009, Healthy Start coalitions and community liaisons engaged in education and outreach activities to promote understanding of the value of risk screening and Healthy Start services. Community liaisons make regular visits to prenatal care provider offices to provide technical assistance regarding screening practices, Healthy Start provider's manuals, brochures, posters, and other helpful resources. Healthy Start screening rate reports and newsletters are developed to showcase screening rates of area providers. Special recognition is given to high screening

performers and those showing rate improvements. Healthy Start coalitions host community events such as health fairs, educational baby showers, prenatal healthcare summits, symposiums, and other community informational forums as additional strategies to promote the value of the program.

The department continued to collaborate with the coalitions and Healthy Families Florida to identify strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. The department provided conference call trainings on screening as appropriate and ad hoc data reports to the coalitions for trend analysis. Healthy Start coalition contracts included screening rates as a core outcome measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start prenatal screening outreach will continue to provide training and technical assistance for all prenatal health care providers.				X
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the bimonthly Infant, Maternal and Reproductive Health meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all pregnant women.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of infant risk screening instrument and strategies for addressing trends of screening data.			X	
5. Community Liaison Bimonthly Conference Calls to provide technical assistance on marketing strategies and consumer response; share information, ideas, and resources; and issues related to provider and consumer outreach regarding risk screening.				X
6. Calculation of the percentage of pregnant women screened by Healthy Start, specified as a core outcome measure in the Healthy Start coalition contracts as of July 1, 2002.				X
7. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and discussion of percentage of women screened by Healthy Start.				X
8.				
9.				
10.				

b. Current Activities

The department continues to provide trainings for Healthy Start community liaisons, care coordination providers, and county health departments, as well as technical resources to aid with successful local implementation. Likewise, community liaisons provide trainings, technical assistance, and screening forms to all prenatal providers within the coalition catchment areas.

Healthy Start coalition contracts include screening rates as a core outcome measure and coalition contract monitoring occurs annually and ad hoc data reports to the coalitions for trend analysis are provided upon request.

We provide Healthy Start screening rate updates on the bimonthly Infant, Maternal and Reproductive Health Meet-Me-Call, quarterly MomCare conference calls, and bimonthly conference calls with the Healthy Start community liaisons. Collaborations continue with the

coalitions and Healthy Families Florida through quarterly meetings, and we continue to offer conference call trainings on screening as needed.

c. Plan for the Coming Year

In FY2011, the department will continue to provide training and technical assistance as needed regarding the revised screen, the revised Healthy Start Standards and Guidelines screening chapter, and the revised HMS components.

The department will continue to assist Healthy Start coalitions as they identify and confront issues that may impact their screening rates. Coalitions will continue to develop, implement, and share strategies to increase prenatal screening rates, provide ongoing technical assistance to communities, and coordinate with the Healthy Families Florida program to reduce duplication of services.

The department will continue to work with the coalitions to identify and implement new strategies for improving the prenatal screening rates, facilitate conference calls with community liaisons, and market the program through the revision and distribution of the Healthy Start prenatal risk screening brochures in English, Spanish, and Creole.

The department will continue to maintain the HealthyStartBaby.com website we developed as a component of the 2007 statewide marketing campaign. The department will continue to hold bimonthly conference calls with community liaisons facilitated on a rotating basis, for information sharing and problem solving, and develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening. We will continue the Infant, Maternal and Reproductive Health bimonthly Meet Me Calls with care coordinators and coalitions in order to share strategies to impact Healthy Start screening rates. We will also continue to provide Healthy Start screening rate updates on the MomCare conference calls. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening rate.

State Performance Measure 6: *The percentage of infants screened by Healthy Start*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	77	77.5	78	82	87
Annual Indicator	73.3	80.3	81.3	86.5	87.9
Numerator	165761	190362	194441	200286	193639
Denominator	226219	237142	239120	231417	220206
Data Source				Florida DOH CHARTS	Florida DOH CHARTS
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	87.3	87.6	88	88.3	

a. Last Year's Accomplishments

Provisional data for 2009 indicate that 87.9 percent of all infants were screened by Healthy Start, which reflects an increase over the final 2008 rate of 86.5 percent. This indicates that more

parents are being informed about the importance of Healthy Start risk screening and encouraged to consent to having their infants screened. Florida's Healthy Start initiative provides for universal screening for infants. This measure is used as an indicator for ensuring all families of infants are offered the Healthy Start infant risk screening as required by Florida statutes. The screen identifies environmental, social, psychosocial, and medical risk factors that make an infant more likely to experience death in the postneonatal period.

The infant screening form is completed in the birthing facility, and it contains risk factors that are also available on the birth certificate. When the parent or guardian consents to the screen, the infant screen report data is extracted from the birth certificate rather than the screening form. If the parent or guardian's screening consent is not expressed or unknown on the birth certificate, the infant will be screened and counted in the screening rate.

The Department's Office of Vitals Statistics (OVS) continued statewide roll-out of an Electronic Birth Registration (EBR) system, which began in 2006. Birth facilities implementing the EBR system also have the capacity to complete the Healthy Start Infant Risk screen as a part of the electronic birth registration process. During 2009, 35 additional hospitals in Florida implemented the EBR system. The department's Infant, Maternal and Reproductive Health Unit (IMRH) provides technical assistance and resource documents to Healthy Start coalitions as they work with hospital staff to ensure a smooth transition from current birth registration practices to the EBR system. IMRH staff acts as a liaison between the Office of Vital Statistics, the Healthy Start coalitions, and local county health department Healthy Start staff.

The department continued to hold bimonthly conference calls with the Healthy Start community liaisons responsible for conducting community outreach activities and to provide education to birth facility staff on the benefits of the Healthy Start program and the importance of offering the parent of each newborn the risk screen in a manner that encourages consent. The community liaison conference calls involve Healthy Start screening data updates, information and strategy sharing, training, technical assistance, and discussion regarding successes and challenges faced while conducting promotion activities.

During 2009, Healthy Start coalitions and community liaisons engaged in a number of education and outreach activities to promote understanding of the value of risk screening and Healthy Start program services. Regular visits to birthing facilities to offer technical assistance regarding screening practices, Healthy Start resource manuals, brochures, screening tip sheets, and other helpful resources were provided by community liaisons throughout the state. In addition, some coalitions funded Healthy Start staff to complete the screening process in hospitals with new moms and others provided special in-hospital incentive programs to encourage consent to Healthy Start risk screening. Additionally, Healthy Start coalitions hosted community events such as health fairs, educational baby showers, prenatal healthcare summits, symposiums, and other community informational forums as additional strategies to promote the Healthy Start program and risk screening.

The department continued to collaborate with the coalitions and Healthy Families Florida to identify innovative strategies to promote the importance of Healthy Start screening and the Healthy Start program through monthly and quarterly meetings. The department also provided conference call trainings on screening as appropriate and ad hoc data reports to the coalitions for trend analysis. Healthy Start coalition contracts included screening rates as a core outcome measure.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Healthy Start infant screening outreach to provide training and				X

technical assistance for birthing facilities.				
2. Strategies to increase screening rates are elicited from county health departments and coalitions on the monthly Healthy Start meet-me-call.				X
3. Promotion of Healthy Start screening as beneficial for all newborn infants.			X	
4. Healthy Start Screening Central Workgroup meetings to discuss annual analysis of infant risk screening instrument and strategies for addressing trends of screening data.				X
5. Community Liaison Bimonthly Conference Calls to provide technical assistance on marketing strategies and consumer response; share information, ideas, and resources; and issues related to provider and consumer outreach regarding risk screening.				X
6. Conduct annual QA/QI monitoring of Healthy Start coalitions and county health departments, which includes review and discussion of percentage of women screened by Healthy Start.				X
7.				
8.				
9.				
10.				

b. Current Activities

The Department's Office of Vital Statistics continues statewide roll-out of the Electronic Birth Registration (EBR) system, which includes offering the Healthy Start Infant Risk screen. A total of 85 of the 117 birthing hospitals in Florida are now on the EBR system. The Infant, Maternal and Reproductive Health Unit continues to provide technical assistance to Healthy Start coalitions and acts as a liaison between the Office of Vital Statistics, the Healthy Start coalitions, and local county health department Healthy Start staff.

Healthy Start coalition contracts include screening rates as a core outcome measure and coalition contract monitoring occurs annually. We provide ad hoc data reports to the coalitions for trend analysis upon request and we continue to produce the Healthy Start annual report.

We provide Healthy Start screening rate updates on the quarterly MomCare conference calls, bimonthly Infant, Maternal and Reproductive Health Meet Me Calls and bimonthly conference calls continue with the Healthy Start community liaisons. Collaborations continue with the coalitions and Healthy Families Florida through monthly and quarterly meetings, and we continue to hold conference call trainings on screening as needed.

c. Plan for the Coming Year

In FY2010, the department's Infant, Maternal, and Reproductive Health Unit will continue to work collaboratively with the Office of Vital Statistics in the progressive statewide roll-out of the Electronic Birth Certificate system, which includes the Healthy Start infant risk screening. Statewide implementation is expected to be completed by June 2010.

The department will continue to provide technical assistance to Healthy Start coalitions, helping them identify and confront issues that may impact their screening rates. Coalitions will continue to develop, implement, and share strategies to increase prenatal screening rates, provide ongoing technical assistance to communities, and coordinate with the Healthy Families Florida program to reduce duplication of services.

The department will continue to work with the coalitions to identify and implement new strategies

for improving the prenatal screening rates, facilitate conference calls with community liaisons, and market the program through distribution of the Healthy Start prenatal risk screening brochures in English, Spanish, and Creole. Additionally, the department plans to design a framework for the revision of the infant risk screen now that the implementation of the revised prenatal risk screen has been fully implemented.

The department will continue to maintain the HealthyStartBaby.com website, which was developed as a component of the statewide marketing campaign held in 2007. The department will continue to hold bimonthly conference calls with community liaisons for information sharing and problem solving, develop ad hoc reports for local use, and solicit additional partners to assist in the promotion of Healthy Start risk screening. The Infant, Maternal and Reproductive Health bimonthly Meet Me Calls with care coordinators and coalitions will continue to occur and be used a medium for sharing new and proven strategies to impact Healthy Start screening rates. We will continue to provide Healthy Start screening rate updates on the MomCare conference calls. Healthy Start coalition contracts will continue to include a core outcome measure on the Healthy Start screening rate.

State Performance Measure 7: *The rate per 1,000 of hospital discharges due to asthma in children 0-14*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective	2.5	2.4	1.8	1.9	1.9
Annual Indicator	2.3	2.2	2.2	1.9	1.2
Numerator	7864	7600	7673	6714	4196
Denominator	3352639	3415172	3448267	3451433	3422458
Data Source				AHCA Hospital Discharge Data	AHCA Hospital Discharge Data
Is the Data Provisional or Final?				Final	Provisional
	2010	2011	2012	2013	2014
Annual Performance Objective	1.8	1.7	1.6	1.5	

Notes - 2009

Data for 2009 is incomplete; includes only first two quarters.

a. Last Year's Accomplishments

Hospital discharges for asthma among 0 -- 14 year-olds decreased from 2.2 per 1,000 in 2007 to 1.9 per 1,000 in FY2008. Data for 2009 is incomplete. The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children 0 -- 14 years of age is calculated with inpatient hospital discharge data from the Florida Agency for Health Care Administration (AHCA) and population estimates for children 0 -- 14 from the Florida Legislature's Office of Economic and Demographic Research (EDR) accessible through the Florida Community Health Assessment Resource Tool Set (CHARTS) - <http://www.floridacharts.com/charts/PopQuery.aspx>.

School Health activities to reduce childhood hospitalization included: in-school care and management (individual care plan and emergency plan development, medication administration, monitoring, and training) and health education (child self-care education, asthma management education) using the American Lung Association's Open Airways for Schools curriculum and partnership promotion for asthma friendly school environments using the federal Environmental

Protection Agency's Tools for Schools. Populations served included pre-kindergarten through 12th grade students, including those with special health care needs.

Annual school health data reflect a decrease in students in pre-kindergarten through 12th grade identified with asthma, from 57.07 per 1,000 for FY2008 to 63.95 per 1,000 for FY2009 (2007-08 and 2008-09 Annual School Health Services Report). School health nurses collaborate with multiple entities to support students with asthma in the school environment while emphasizing prevention and early detection, and individual in-school case management. This includes review of student health information obtained through consultation with parents and physicians, observations from school personnel and health care providers, nursing assessments, record reviews, referral and follow-up, provider ordered medications and/or procedures, and health education. These activities are designed to enable school nurses to work with students to better manage their asthma and avoid hospitalization.

The Florida Department of Health (DOH) county health departments, and community partners provided technical assistance and asthma information via Web links, health education training materials, and patient brochures. Partnerships were developed with Environmental Health, School Health Services, the Environmental Protection Agency, and the Centers for Disease Control and Prevention (CDC) to facilitate these activities.

Infrastructure-building services are ongoing in many DOH programs and include supporting education and prevention initiatives through the provision of expertise, technical assistance, and guidance in childhood asthma management and care, and provision of asthma resources to community health care providers, schools, day care facilities, children and families.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Asthma education and prevention efforts through Healthy Start coalitions and county health department (CHD) school health programs to reduce asthma hospitalizations and re-hospitalizations for children.	X			
2. Training and educational initiatives to improve the early identification of high-risk young children with asthma and assist in establishing a medical home for children with asthma.		X		
3. Provision of technical assistance and supportive asthma resources and training materials to Healthy Start coalitions and CHDs.			X	
4. Provision of childhood asthma educational web links, health education training materials and patient brochures and posters to Healthy Start coalitions, CHDs, and community partners.			X	
5. Development of a child health strategic plan for Florida's children to address early identification, diagnosis, and treatment of children at high risk for asthma.				X
6. Partnerships with Environmental Health, EPA, and CDC that address asthma reduction and asthma control.				X
7.				
8.				
9.				
10.				

b. Current Activities

The department collaborates with public/private organizations to reduce indoor and outdoor environmental factors that contribute to asthma in children. Partners include local county health departments, hospitals, health care providers, advocacy organizations, and universities. We address lay public and health care provider education and training, and indoor and outdoor air quality issues. To raise awareness of childhood asthma, county health department staff serves on community health advisory boards, local early learning coalitions and school health advisory committees that provide input for schools, childcare programs, early care and education agencies, and Head Start programs. The department's Environmental Public Health Tracking Program links environmental and asthma hospital data in order to learn more about environmental factors such as wildfires and emergency room visits for individuals living with asthma.

The School Health Services Program provides technical assistance regarding school health clinic procedures for asthma management in the Florida School Health Administrative Guidelines (2007) and the Nursing Guidelines for the Delegation of Care for Students with Asthma in Florida Schools (2005). These guidelines provide administrative and clinical guidance for school nurses providing health services to students with asthma, along with numerous links to asthma related resources.

c. Plan for the Coming Year

The Department of Health will continue to partner with state and national agencies to reduce airborne pollutants in homes, schools, and workplaces. Reductions in re-hospitalization are an indicator of the health care system's success in helping families and children manage and control asthma. Through a number of DOH programs, we provide existing childhood asthma resources for the county health departments to educate their staff, health care providers, children, and families about the disease and how it is affected by environmental prompts.

In FY2011, the School Health Services Program will continue to work with the county health departments and their school health programs to promote childhood asthma education and prevention activities for children and their families, and provide resources to assist school nurses with school-based asthma management to reduce hospitalizations of students with asthma. In addition, the program office staff will continue to partner with DOH Environmental Health staff and community agencies and organizations to improve the early identification of young children with asthma and promote the establishment of medical homes for children with asthma. It is a priority of the department to raise public awareness and educate the public that severe asthma episodes can be prevented through early identification, monitoring, and proper management of the disease.

State Performance Measure 8: *Excess feto-infant mortality attributed to the maternal health/prematurity category in the PPOR statewide analysis.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Performance Objective		3.7	2.6	2.6	2.5
Annual Indicator	2.4	2.7	2.9	2.8	
Numerator	263	321	361	329	
Denominator	111726	120919	123318	117879	
Data Source				Florida birth, infant death, fetal records.	
Is the Data Provisional or Final?				Final	

	2010	2011	2012	2013	2014
Annual Performance Objective	2.5	2.4	2.4	2.4	

Notes - 2009

Data for 2009 are not yet available. Requires matching infant death to births, and infant death records are not closed. Full data on infant deaths linked to births will not be available until April 2011.

Notes - 2007

Data for 2007 are not yet available.

a. Last Year's Accomplishments

The Perinatal Periods of Risk (PPOR) analysis performed by the Florida Department of Health for the years 1998-2007, indicated that maternal health prior to and during pregnancy largely affected the health and well-being of the infant. Prenatal care is often too late to prevent serious maternal and infant health problems. Preconception care is now recognized as a critical component for all women of reproductive age (Center for Disease Control Mortality and Morbidity Weekly Review (MMWR), April 2006).

Healthy Start continues to play an active statewide role in preconception and interconception health for women in Florida. Healthy Start services are available to women statewide who have risks that may impact their pregnancy outcome. Through Healthy Start, interconception risk screening, education and counseling, and needed referrals are being provided to Healthy Start prenatal clients, to the mother of a Healthy Start enrolled infant, or to a Healthy Start woman who has experienced a fetal loss or miscarriage. Counseling may be provided to an individual or in a group setting, but must be provided in person. Changes to rule were made in order to provide and code for services for the interconception woman to include the woman who is past the six week postpartum period but has no infant to code due to fetal loss, adoption, miscarriage, etc.

Topics that must be addressed in each curriculum include: access to care, baby spacing, nutrition, physical activity, maternal infections including immunization status and periodontal disease, chronic health problems, substance abuse, smoking, mental health, and environmental risk factors. Mothers of infants who were born prior to 37 weeks gestation or under 2500 grams at birth or with congenital abnormalities, teen mothers, and those with chronic health conditions are critical groups considered for these services; however, any woman may have risk factors that could be mitigated through intervention or behavioral change implemented prior to embarking on a subsequent pregnancy.

The department also continues to promote technical assistance guidelines that direct preconception and interconception education and care topics that should be provided to women of childbearing age who access clinical care within the county health department programs. Educational presentations have been shared with providers in Children's Medical Services, prenatal care, school health, and family planning programs.

The department collaborated with the Florida Chapter March of Dimes in the VitaGrant project. Over the grant period, the project distributed 565,000 bottles of multivitamins containing 400 mcg of folic acid and preconception education to non-pregnant, low-income women of childbearing age.

The Department of Health received funding from the March of Dimes for the promotion of the Every Woman Florida campaign. The components of Every Woman Florida included a social marketing/awareness campaign and the establishment of a statewide Preconception Health Advisory Council. This purpose of this initiative was to encourage providers across specialties to integrate screening of all women of childbearing age and offer interventions for any identified health risk factors that may ultimately lead to a poor birth outcome.

The Every Women Florida Preconception Health Council merged with the March of Dimes Prematurity Workgroup to enhance the integration, development and promotion of preconception care. The focus remains on engaging stakeholders in a process to increase awareness, availability and access to preconception care for women of childbearing age in Florida. The initiative serves to prioritize issues through regular meetings of a multi-disciplinary committee and will provide direction for meeting the following goals:

- Elimination of disparities in preconception health
- Set policy agenda to promote preconception care
- Provide information to stakeholders
- Educate consumers and providers
- Promote a research strategy on preconception care
- Integrate preconception care in clinic and public health practice

Under the social marketing component of the initiative, a website was created to serve as an information portal to address the knowledge, attitudes and behaviors of providers and consumers. The goal is to raise awareness on the importance of being healthy before one conceives and promote effective provision of services that will assist individuals to change or modify their health behaviors.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Interconception Education and Counseling provided through Healthy Start according to Healthy Start Standards and Guidelines, Chapter 21.		X		
2. County health departments providing preconception and interconception education according to Technical Assistance Guidelines: Maternal 11.		X		
3. Training and education on preconception and interconception interventions offered to clinical providers who interact with women of childbearing age, such as family planning, school health, visiting doula programs, CMS and private sector providers.				X
4. Maintain and support the Every Woman Florida Preconception Health Initiative.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The department continues to foster the growth of the Every Woman Florida Preconception Health Initiative by offering Grand Rounds at various hospitals around the state. Through the additional funding from the March of Dimes, physicians have been recruited to deliver the preconception messages to health care workers in their participating facilities. Toolkits including educational materials and resources will be distributed to all participants.

Healthy Start coalition and county health department staff are working to promote health for women of reproductive age through screening, education, increasing access to services, and marketing efforts aimed at consumers and providers. Standards, guidelines, and coding structures are in place so Healthy Start providers can provide and track interconception education

services provided to clients. Biannual training on the topic of interconception education and counseling remains part of Healthy Start core training. At the local level, coalitions train their staff as well as community provider staff on interconception topics and appropriate use of their approved curriculums.

c. Plan for the Coming Year

The department was part of a seven state collaborative working with the Centers for Disease Control to identify core state indicators to monitor the health of reproductive age women. These indicators will be used to assess, monitor, and evaluate overall preconception health and the effectiveness of interventions. The State of Florida is currently developing their first Preconception Health Indicator Report to be distributed to policy makers, health care providers, legislators and key partnering agencies.

We will continue to train our county health department providers working with women of reproductive health age to incorporate preconception health screening, education, and services into their existing practices based on existing preconception health guidelines. We will continue to collaborate with the March of Dimes to promote preconception health and encourage women to access early prenatal care.

Healthy Start will continue to provide interconception education to participants. The department will help the few coalition areas not currently providing this service to develop or adopt a curriculum, train staff, and build capacity to provide interconception education. Only four counties have been unable to offer this service to date. .

The department will continue to provide education and training to public and private providers who interact with women of childbearing age in any capacity so they can reinforce preconception and interconception topics with their clients.

Florida's Pregnancy Associated Mortality Review (PAMR) team and 12 state funded Fetal Infant Mortality Review (FIMR) projects will continue to collect data to identify factors associated with adverse birth outcomes.

E. Health Status Indicators

Introduction

Tracking of the health status indicators includes gathering and evaluating data on low birth weigh, very low birth weight, unintentional injuries, and chlamydia. The surveillance and monitoring of these indicators on an annual basis provides insight into the progress made as we address these particular health issues. Careful evaluation helps direct us in our strategic planning efforts, and helps ensure we direct time and resources towards areas of need where we can have a positive impact on Florida citizens.

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	8.8	8.7	8.7	8.8	8.7
Numerator	19802	20714	20767	20369	19165
Denominator	226183	237138	239120	231417	220202

Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Factors that may contribute to the risk of low birth weight and very low birth weight include mother's race, age, multiple birth, education, socioeconomic status, and substance use during pregnancy. Black infants are twice as likely as white infants to be born at a low birth weight, and black mothers accounted for 22.2 percent of resident live births in Florida in 2008. In 2008, 19.6 percent of all mothers had less than a high school education. A total of 15,656 mothers (6.8 percent) reported they smoked during pregnancy. Of all babies born that year, 7,516 were multiple births. Many of these factors are difficult to address, particularly in trying economic times. As more families face difficulties such as job loss, inadequate health care coverage, displacement from their homes, and poor nutrition, resources to address low birth weight risks are becoming scarcer.

The Department of Health and its partners are engaging in a number of strategies to address both low and very low birth weight. We have seen an increase in funding of Florida Healthy Start for prenatal support services through a Medicaid Waiver and an increase in state funding. We continue to promote prenatal smoking cessation through public awareness and the provision of classes, counseling and cessation methods as resources are available. We have expanded the WIC prenatal caseload, and increased the percentage of pregnant women whose delivery is paid for by Medicaid. We are starting new preconception health initiatives, and have looked at more effective ways of providing prenatal care. We are also strengthening our family planning efforts including our Medicaid family planning waiver.

The percent of live births weighing less than 2,500 grams: The percentage of infants born low birth weight in Florida increased 2.3 percent from 8.6 percent in 2004 to 8.8 percent in 2008, with a provisional rate of 8.7 in 2009. The increase is statistically significant ($P < 0.001$ percent). From 2007 to 2008, the low birth weight percentage increased 1.0 percent. An increase in the number of low birth weight babies raises the risk of infant mortality, morbidity and developmental disability, and also causes greater health care costs. The percentage of twins and multigestation pregnancies is no longer increasing in Florida and does not contribute to these recent trends. We have recently studied the increase in preterm and late preterm births, a major determinant of low birth weight. The following do not explain the increase in preterm delivery in Florida: multiple gestations, maternal age, maternal race, maternal ethnicity, parity, maternal education, or marital status. Approximately one-third of the increase in preterm births is related to Cesarean delivery. We are currently finalizing a hospital abstraction study to confirm birth certificate findings.

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.0	7.1	7.0	7.0	7.0
Numerator	15381	16229	16218	15754	14886
Denominator	219025	229683	231547	223888	213047
Check this box if you cannot report the					

numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Same as HIS #01A above, except for the following data interpretation.

The percent of live singleton births weighing less than 2,500 grams: In Florida the percentage of singleton infants born low birth weight increased 2.7 percent from 6.9 percent in 2004 to 7.0 percent in 2008, with a provisional rate of 7.0 in 2009. The increase is statistically significant ($P < 0.01$ percent). From 2007 to 2008, the singleton low birth weight percentage increased 0.1 percent. The difference between all births with low birth weight (8.8 percent) and singleton births with low birth weight (7.0 percent) in 2008 is attributable to multiple births. Studies have shown that more than half of twins and other multiples are born low birth weight. Previous increases in multiple births have been associated with older age at childbearing and an increase in fertility therapies.

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.6	1.6	1.6	1.7	1.6
Numerator	3637	3807	3886	3851	3520
Denominator	226183	237138	239120	231417	220202
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Same as HIS #01A above, except for the following data interpretation.

The percent of live births weighing less than 1,500 grams: In Florida the percentage of infants born very low birth weight in Florida increased 6.1 percent from 1.6 percent in 2004 to 1.7 percent in 2008, with a provisional rate of 1.6 in 2009. The increasing trend is statistically significant ($P < 0.01$ percent). From 2007 to 2008, the very low birth weight percentage increased 2.1 percent. The risk of early death for infants born with very low birth weight is more than 100 times that of infants born at more than 2,500 grams.

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	1.3	1.3	1.3	1.3	1.3
Numerator	2806	2951	3036	2919	2689
Denominator	219025	229683	231547	223888	213047
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Same as HIS #01A above, except for the following data interpretation.

The percent of live singleton births weighing less than 1,500 grams: In Florida the percentage of singleton infants born very low birth weight in Florida has remained at 1.3 percent from 2003 to 2008, and the provisional rate for 2009 is also 1.3 percent. The difference between all births with very low birth weight (1.7 percent) in 2008 and singleton births with very low birth weight (1.3 percent) in 2008 is attributable to multiple births.

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	11.4	10.7	11.3	9.0	7.7
Numerator	382	363	391	311	265
Denominator	3352639	3403203	3448267	3449949	3422458
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The death rates from unintentional injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 30 of the 67 counties and covers 82 percent of the children ages 14 and under. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. There is discussion to establish another chapter in Naples, Collier County. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger remained relatively stable year to year from 2003 through 2007. Overall, the death rate decreased less than 1 percent from 2003 to 2007

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	4.2	3.1	3.2	1.9	1.8
Numerator	142	107	110	66	62
Denominator	3352639	3403203	3448267	3449949	3422458
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The rates of all non-fatal injuries and motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 30 of the 67 counties and covers 82 percent of the children ages 14 and under. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties.

Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. There is discussion to establish another chapter in Naples, Collier County. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes decreased almost every year between 2004 and 2008. Overall, the death rate decreased 58 percent from 2004 to 2008.

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	34.2	33.9	30.3	26.6	19.3
Numerator	799	807	734	643	466
Denominator	2334592	2380124	2423169	2421365	2413540
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The 2003-2008 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing the Primary Seat Belt law, effective June 30, 2009, we anticipate increased seat belt usage, which should further reduce motor vehicle crash injuries and deaths.

The death rate per 100,000 for unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years fluctuated year to year from 2004 to 2007. However, in 2008, the death rate decreased 16 percent from the previous year.

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	189.9	175.7	172.9	178.4	183.9
Numerator	6366	5980	5962	6154	6294
Denominator	3352639	3403203	3448267	3449949	3422458
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. Florida has a Safe Kids presence in 30 of the 67 counties and covers 82 percent of the children ages 14 and under. . In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. There is discussion to establish another chapter in Naples, Collier County. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of all non-fatal injuries among children aged 14 years and younger decreased every year from 2004 to 2007. However, in 2008, the hospitalization rate increased 3 percent from the previous year. Still, the overall hospitalization rate decreased 11 percent from 2004 to 2008.

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	33.8	28.8	26.7	23.1	23.5
Numerator	1132	979	919	797	804
Denominator	3352639	3403203	3448267	3449949	3422458
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The rates of all non-fatal injuries and non-fatal injuries from motor vehicle crashes among children ages 14 years and younger are influenced by Florida's ability to maintain a strong Safe Kids Coalition and Chapter network. The Office of Injury Prevention is the lead agency for Safe Kids Florida, the statewide organization. In 2008, the childhood unintentional injury fatality rate in Safe Kids counties was 31 percent lower than the rate in non-Safe Kids counties which corresponds to 106 fewer deaths than expected had the fatality rate been the same as non-Safe Kids counties. Safe Kids conducts community activities that provide education on prevention of children's unintentional injuries. Child passenger safety education and child safety seat check ups events are a regular Safe Kids' activity.

Safe Kids Florida, Office of Injury Prevention staff, is working to establish additional Safe Kids Chapters in areas without a Safe Kids presence. There is discussion to establish another chapter

in Naples, Collier County. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions. Safe Kids Florida is working to provide additional resources to Safe Kids Chapters and Coalitions.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among children aged 14 years and younger decreased every year from 2004 to 2008. Overall, the hospitalization rate decreased 34 percent from 2004 to 2008.

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	155.3	168.3	164.2	140.9	140.1
Numerator	3625	4005	3980	3412	3382
Denominator	2334592	2380124	2423169	2421365	2413540
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

The 2003-2007 Florida data reflects a national trend in a decreasing death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years. Several factors to consider are increased awareness of traffic safety issues, Click-it or Ticket campaign, etc., decreased exposure due to decreased miles driven, higher cost of gasoline and the weakening economy. With Florida recently passing a primary seat belt law, effective June 30, 2009, we anticipate increased belt usage, which should have a corresponding reduction in motor vehicle crash injuries and deaths.

The hospitalization rate per 100,000 of non-fatal injuries due to motor vehicle crashes among youth aged 15 through 24 years increased each year from 2004 to 2006. However, the hospitalization rate decreased each year from 2006 to 2008. Overall, the hospitalization rate decreased 6 percent from 2004 to 2008 and 16 percent from 2006 to 2008.

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	23.2	25.3	27.1	28.3	28.3
Numerator	13372	14815	16111	16737	16641
Denominator	576265	585832	594306	592198	588376
Check this box if you cannot report the numerator because					

1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Narrative:

Close examination of the disease distribution reveals that 80 percent of all reported cases of chlamydia are reported in populations 26 and under; further, Chlamydia trachomatis is the most prevalent sexually transmitted bacterial infection reported among 15-24 year olds in Florida. The highest rate occurs among females 15-19 (3.2 per 1,000 population), regardless of gender/age group comparisons. When single age groups are compared, cases reported peaked at the age of 19 (mean=19.7) with a gradual decline of cases as single age in years increased.

Chlamydia trends and rates continue to rise in 15-19 years olds in the state. Some of this rise may be explained by the increase in testing, improved access to care afforded to clients in clinics and county health departments, increase in electronic lab reporting, and shifting of testing technology to a more sensitive and specific test in the past two years. Additionally, increased disease awareness, HEDIS performance measures, and Healthy People 2010 benchmarks have prompted communities to increase screening in a population of sexually active females that has been previously underserved as well as uninsured.

Adolescent women may have a physiologically increased susceptibility to chlamydia trachomatis infection. The higher prevalence of STDs among adolescents reflects multiple barriers to quality STD prevention services, including lack of insurance or other ability to pay, lack of transportation, discomfort with facilities and services designed for adults, and concerns about confidentiality. Florida's STD program has evolved to address these various needs. In 2009, management of cases was prioritized to ensure the needs of pregnant females, neonates, and adolescents were being met. We continue to collaborate with Florida private labs for electronic reporting of morbidity and provide adequate verification of treatment and/or intervention to private clients. The bureau maintains its relationships with managed care organizations, and incorporates health promotion activities into the populations most affected. In hopes of decreasing the prevalence and incidence of chlamydia, and their associated complications when left untreated, the Bureau of STD continues to implement these and other strategies as needed.

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	2005	2006	2007	2008	2009
Annual Indicator	7.1	7.7	8.5	9.0	9.1
Numerator	20599	22648	25204	26631	26535
Denominator	2918644	2952588	2973869	2951483	2916948
Check this box if you cannot report the numerator because 1. There are fewer than 5 events over the last year, and 2. The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					

Is the Data Provisional or Final?				Final	Provisional
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Narrative:

Similar to national trends, Florida statistics over the past years continue to indicate a significant rise in cases of chlamydia in the 15-24 age group. Compared to older adults, adolescents (10-19) and young adults (20-24) are at higher risk for acquiring STDs for a number of reasons, they may be more likely to have multiple (sequential or concurrent) sexual partners rather than a single, long-term relationship and they may select partners at higher risk. Historically, chlamydia morbidity is low in females over the age of 30. The greatest need occurs in younger age cohorts.

Florida's STD program has had significant changes in health service delivery in the past five years. These changes have included a shift in testing technology for chlamydia and gonorrhea, expansion of Infertility Prevention Project funded sites, and radical changes in the way data is collected. The Bureau of STD supports the national screening criteria recommended by CDC. The bureau also aligns with Healthy People 2010 STD Objectives. Any client who enters a STD clinic is offered a chlamydia and gonorrhea test. Male partners who attend family planning clinics are offered services as well to effectively interrupt the transmission of disease.

We continue to collaborate with Florida private labs for electronic reporting of morbidity and provide adequate verification of treatment and/or intervention to private clients. The bureau maintains its relationships with managed care organizations, and incorporates health promotion activities into the populations most affected. In hopes of decreasing the prevalence and incidence of chlamydia, and their associated complications when left untreated, the Bureau of STD continues to implement these and other strategies as needed.

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	227360	166150	52170	254	2654	95	6037	0
Children 1 through 4	909441	664598	208682	1015	10616	382	24148	0
Children 5 through 9	1137318	844330	249657	1485	14512	339	26995	0
Children 10 through 14	1148339	861191	244459	1892	12390	358	28049	0
Children 15 through 19	1203142	892917	264761	2214	13318	469	29463	0
Children 20 through 24	1210398	901421	264425	1437	12714	483	29918	0
Children 0 through 24	5835998	4330607	1284154	8297	66204	2126	144610	0

Notes - 2011

Narrative:

Population estimates for 2009 show there were 5,835,998 children younger than 24. Of that number, 4,330,607 (74.2 percent) are white and 1,284,154 (22 percent) are black. Florida only

gathers race data categorized as race white, black, or other. Estimates for other racial groups are based on proportion of 2009 deliveries in that racial group. Of all children up through age 24, we estimate there were 8,297 American Indians or Native Alaskans (0.14 percent), 66,204 Asians (1.13 percent), and 2,126 Native Hawaiians or other Pacific Islanders (0.04 percent). A total of 144,610 (2.48 percent) reported more than one race. There were no significant changes in the percentages for each race when broken down by the specific age groups listed on Form 21.

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	163645	63715	0
Children 1 through 4	654581	254860	0
Children 5 through 9	834446	302872	0
Children 10 through 14	863173	285166	0
Children 15 through 19	914131	289011	0
Children 20 through 24	920456	289942	0
Children 0 through 24	4350432	1485566	0

Notes - 2011

Narrative:

Florida does not gather data on the number of Hispanics. In order to complete HSI #06B the Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2009 population of 0-24 year olds by race-ethnicity. According to those projections, of the 5,835,998 children 24 or younger, 25.5 percent are identified as Hispanic or Latino.

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Women < 15	256	110	132	1	2	0	10	1
Women 15 through 17	6271	3688	2393	22	16	2	125	25
Women 18 through 19	15617	9933	5173	41	80	15	300	75
Women 20 through 34	165681	119878	37145	346	4746	117	2024	1425
Women 35 or older	32381	24628	5550	49	1482	19	303	350
Women of all ages	220206	158237	50393	459	6326	153	2762	1876

Notes - 2011

Narrative:

Provisional data for 2009 indicate there were 220,206 total live births in Florida during 2008. This represents a significant decrease from the previous year as 230,167 total births were reported in 2008. Of the 2009 provisional total, 158,237 were white (71.9 percent), 50,393 were black (22.9 percent), 459 were American Indian or Native Alaskan (0.2 percent), 6,326 were American Indian or Native Alaskan (2.9 percent), and 153 were Native Hawaiian or Other Pacific Islander (0.1 percent). More than one race was reported for 2,762 births (1.3 percent) and 1,876 births were other or unknown (0.9 percent).

Of the total births, women younger than 15 had 256 babies (0.12 percent of the total), women 15 through 17 had 6,271 babies (2.86 percent), women 18 through 19 had 15,617 babies (7.09 percent), women 20 through 34 had 165,681 babies (75.24 percent), and women 35 or older had 32,381 babies (14.7 percent).

When compared to whites, black women account for a disproportionate number of births at younger ages. While 71.9 percent of the total births were white and 22.9 percent were black, births to women less than 15 were 43 percent white and 51.6 percent black. Births to women 15 through 17 were 58.8 percent white and 38.2 percent white. Births to women 18 through 19 were 63.6 percent white and 33.1 percent black. White and black women 20 through 34 were broken down by race at percentages similar to the total births, with white women accounting for 72.4 percent of the births and black women 22.4 percent of the births in that age category. White women account for a disproportionate number of births to women 35 or older, where 76 percent of the births were white and 17.4 percent were black.

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Total live births			
Women < 15	187	69	0
Women 15 through 17	4379	1849	43
Women 18 through 19	11329	4174	114
Women 20 through 34	118374	46376	931
Women 35 or older	22766	9397	218
Women of all ages	157035	61865	1306

Notes - 2011

Narrative:

Of the 220,206 births in 2009 (provisional), 157,035 (71.3 percent) were not Hispanic or Latino, 61,865 (28.1 percent) were Hispanic or Latino, and 1,306 (0.6 percent) were ethnicity not reported.

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown
Infants 0 to 1	1481	756	652	0	14	1	38	20
Children 1 through 4	278	170	91	1	4	0	10	2
Children 5 through 9	124	76	41	0	1	0	5	1
Children 10 through 14	162	104	47	0	3	0	1	7
Children 15 through 19	645	445	182	1	6	0	9	2
Children 20 through 24	1242	883	324	4	16	1	7	7
Children 0 through 24	3932	2434	1337	6	44	2	70	39

Notes - 2011

Narrative:

Of the 3,932 total deaths to children 24 and younger, 2,434 (61.9 percent) were white, 1,337 (34 percent) were black, 6 were American Indian or Native Alaskan, 44 were Asian, two were Native Hawaiian or Other Pacific Islander, 70 were more than one race reported, and 39 were other or unknown. There were 1,481 deaths from birth to age 1, white infants accounted for 756 deaths (51 percent) and black infants accounted for 656 deaths (44 percent) in that age category, yet black infants account for just 22.9 percent of infants 0-1. Black children account for about 22 percent of the population in all other ages groups on this form, yet they account for 32.7 percent of the deaths in children 1 through 4, 33.1 percent of the deaths in children 5 through 9, 29 percent of the deaths in children 10 through 14, 28.2 percent of the deaths in children 15 through 19, and 26.12 percent of the deaths in children 20 through 24. Overall, in children from birth through 24, black children account for 22 percent of the population, and 34 percent of the deaths. In contrast, white children account for 74.2 percent of the population from birth through 24, but only 61.9 percent of the deaths.

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported
Infants 0 to 1	1142	330	9
Children 1 through 4	222	56	0
Children 5 through 9	86	38	0
Children 10 through 14	124	38	0
Children 15 through 19	521	124	0
Children 20 through 24	998	242	2
Children 0 through	3093	828	11

24			
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Notes - 2011

Narrative:

Of the 3,932 total deaths to children 24 and younger, 3,309 (78.7 percent) were not Hispanic or Latino. Of the total deaths, 828 (21.1 percent) were Hispanic or Latino, even though children of those ethnicities account for 25.5 percent of the children 0 through 24. Hispanic or Latino infants account for 28 percent of infants from birth to 1, yet only 22.3 percent of the infant deaths. For children 1 through 4, Hispanic or Latino children account for 28 percent of the population and 20.1 percent of the deaths. For children 5 through 9, Hispanic or Latino children account for 26.6 percent of the population and 19.5 percent of the deaths. For children 10 through 14, Hispanic or Latino children account for 24.8 percent of the population and 30.6 percent of the deaths. For children 15 through 19, Hispanic or Latino children account for 24 percent of the population and 19.2 percent of the deaths. For children 20 through 24, Hispanic or Latino children account for 24 percent of the population and 21.1 percent of the deaths.

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	Total All Races	White	Black or African American	American Indian or Native Alaskan	Asian	Native Hawaiian or Other Pacific Islander	More than one race reported	Other and Unknown	Specific Reporting Year
All children 0 through 19	4625600	3429186	1019729	6860	53490	1643	114692	0	2009
Percent in household headed by single parent	16.3	13.4	22.9	36.2	18.7	59.3	10.4	0.0	2009
Percent in TANF (Grant) families	1.0	0.4	2.1	1.6	0.1	9.0	1.0	1.0	2009
Number enrolled in Medicaid	1911795	1092906	596902	4488	18107	679	69	198644	2009
Number enrolled in SCHIP	276607	67517	22525	66	3343	259	16104	166793	2009
Number living in foster home care	6202	3566	2293	5	18	3	272	45	2009
Number enrolled in food stamp program	1335809	632298	461688	2990	4726	2578	18243	213286	2009
Number enrolled in WIC	433136	282656	131483	716	3402	302	12270	2307	2009
Rate (per 100,000) of juvenile crime arrests	2991.4	2147.0	6271.7	1720.1	895.5	11868.5	2991.4	2991.4	2009
Percentage of high	2.3	1.6	3.4	2.3	0.8	2.3	1.6	2.3	2009

school drop-outs (grade 9 through 12)									
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Notes - 2011

“All”, “White”, and “Black” estimates come from 2009 Florida CHARTS population projections: <http://www.floridacharts.com/charts/population.aspx>. Estimates for the total number in the other racial and ethnic groups come from the 2006-2008 American Community Survey: http://factfinder.census.gov/servlet/CustomTableServlet?_ts=195386930898. This total number is then converted to a percentage of the total Florida 0-19 year old population using the 2008-08 American Community Survey. This proportion is then applied to the “Total All Races” in Column 1, Row 1 of this form, and the resulting number deducted from the “Other and unknown” in Column 9, Row 1 and placed in the proper race column of Row 1. When the total from the American Community Survey generated estimates is greater than the “Other and unknown” in Column 9, Row 1, then a “0” is placed in this cell, and the American Community Survey generated estimates are recalculated in proportion to the “Other and unknown” total.

Estimated based on the 2006 American Community Survey: http://factfinder.census.gov/servlet/IPCharIterationServlet?_ts=195391731667. Percent of children under 18 living in single-parent female household: The number of race or ethnicity category households multiplied by the percentage of female/male only households, where there is no husband/wife, but there is a child <18 years that is her/his own; divided by the total number of children in race or ethnic category.

Total TANF participants in 2009 were 73,357

The source for this data includes Hispanic as a race. To estimate counts that would include Hispanic ethnicity in the race categories, The Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2009 population of 0-19 year olds by race-ethnicity. The proportion of Hispanics were calculated by race from the Office of Planning, Evaluation, and Data Analysis projections. These proportions were then applied to the count of Hispanics provided by the data source. These values were then added to the appropriate race category above to attain a total under each race category that included Hispanic ethnicity. Finally, this count value was used to calculate column percentages. For 2009, the projected percentage of Hispanics that were White was 94.39%; the percentage of Hispanics that were Black was 4.29%; and the percentage of Hispanics that were Other was 1.32%.

The source for this data includes Hispanic as a race. To estimate counts that would include Hispanic ethnicity in the race categories, The Florida Department of Health, Office of Planning, Evaluation, and Data Analysis provided projections for the 2009 population of 0-19 year olds by race-ethnicity. The proportion of Hispanics were calculated by race from the Office of Planning, Evaluation, and Data Analysis projections. These proportions were then applied to the count of Hispanics provided by the data source. These values were then added to the appropriate race category above to attain a total under each race category that included Hispanic ethnicity. Finally, this count value was used to calculate column percentages. For 2009, the projected percentage of Hispanics that were White was 94.39%; the percentage of Hispanics that were Black was 4.29%; and the percentage of Hispanics that were Other was 1.32%.

When an estimate cannot be provided for a specific race category, then the overall value for all races is used. In the case of counts, the estimated numbers based on the overall value is subtracted from the “Other and Unknown” column value.

Narrative:

Of children 19 and younger in Florida, 16.3 percent live in a household headed by a single parent, 13.4 percent of white children and 22.9 percent of black children. About 1 percent of all children live in families that receive Temporary Assistance for Needy Families (TANF) grants, 0.44 percent of white children and 2.1 percent of black children. There are 1,911,795 children 19 and younger on Medicaid, 1,092,906 white children and 596,902 black children. A total of 267,607 children are enrolled in SCHIP, 67,517 white children and 22,525 black children. Of the 6,202 children 19 and younger in foster care, 3,556 are white and 2,293 are black. A total of 1,335,809 children are enrolled in the food stamp program, 632,298 white children and 461,688 black children. There are 433,136 children enrolled in WIC, 282,656 are white and 131,483 are black. The rate for juvenile crime arrest in Florida is 2,991 per 100,000, with a rate of 2,147 per 100,000 for whites and 6,271 per 100,000 for blacks. In Florida, 2.3 percent of children are high school dropouts, 1.6 percent of white children and 3.4 percent of black children. Numbers or estimates for other races can be found in Form 21, #09A.

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity.*
(Demographics)

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	Total NOT Hispanic or Latino	Total Hispanic or Latino	Ethnicity Not Reported	Specific Reporting Year
All children 0 through 19	3429976	1195624	0	2009
Percent in household headed by single parent	16.8	14.9	0.0	2009
Percent in TANF (Grant) families	1.1	0.8	1.0	2009
Number enrolled in Medicaid	1345843	565952	0	2009
Number enrolled in SCHIP	27812	62004	186791	2009
Number living in foster home care	5218	885	99	2009
Number enrolled in food stamp program	902422	433387	0	2009
Number enrolled in WIC	257991	175145	0	2009
Rate (per 100,000) of juvenile crime arrests	3451.6	1671.3	2991.4	2009
Percentage of high school drop- outs (grade 9 through 12)	2.1	2.5	2.1	2009

Notes - 2011

The population of Florida's Hispanic and non-Hispanic came from 2009 state projections provided by The Florida Department of Health, Office of Planning, Evaluation, and Data Analysis.

Estimated based on the 2006-08 American Community Survey:

[http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=Percent of children under 18 living in single-parent female/male only household](http://factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=Percent%20of%20children%20under%2018%20living%20in%20single-parent%20female/male%20only%20household): The number of race or ethnicity category households multiplied by the percentage of female/male households, where there is no husband/wife, but there is a child <18 years that is her/his own; divided by the number of children in race or ethnic category.

Total TANF participants in 2009 was 62,838.

Estimation of Non-Hispanic percentage of high school drop-outs, based on the 2009 reported percentage of 3.1% for Hispanic/Latinos and the 2009 overall 2.6% drop-out rate for all races in Row 11, Column 1 of HIS #09A. $(3.1 \times X) / 2 = 2.6$; $X = 2.1$

Estimation of Non-Hispanic percentage of high school drop-outs, based on the 2009 reported percentage of 3.1% for Hispanic/Latinos and the 2009 overall 2.6% drop-out rate for all races in Row 11, Column 1 of HIS #09A. $(3.1+X)/2=2.6$; $X=2.1$

Narrative:

Of children 19 and younger identified as Hispanic or Latino, 14.9 percent live in a household headed by a single parent, compared to 16.8 percent who are not Hispanic or Latino. About 0.7 percent of Hispanic or Latino children live in TANF families, compared to 1.1 percent of children who are not Hispanic or Latino. Of the 1,911,795 children 19 and younger on Medicaid, 565,952 are Hispanic or Latino. Of the 267,607 children enrolled in SCHIP, 62,004 are identified as Hispanic or Latino. Of the 6,202 children 19 and younger in foster care, 885 are Hispanic or Latino. Hispanic or Latino children account for 433,387 of the 1,335,809 children in the food stamp program. Of the 433,136 children in WIC, Hispanic or Latino children account for 175,145 of the total. The rate for juvenile crime arrest for Hispanic or Latino children is 1,671 per 100,000, compared to 3,451 per 100,000 for children who are not Hispanic or Latino. About 2.5 percent of Hispanic or Latino children are high school dropouts, compared to 2.1 percent of those who are not Hispanic or Latino.

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	Total
Living in metropolitan areas	0
Living in urban areas	4162010
Living in rural areas	498696
Living in frontier areas	0
Total - all children 0 through 19	4660706

Notes - 2011

Narrative:

In Florida, 4,162,010 children 19 and younger live in urban areas, and 498,696 live in rural areas.

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	18812156.0
Percent Below: 50% of poverty	5.7
100% of poverty	13.1
200% of poverty	33.5

Notes - 2011

Narrative:

Of the 18,812,155 people living in Florida, we estimate that 5.7 percent live below 50 percent of the federal poverty level. Approximately 13.1 percent live below 100 percent of the federal poverty level, and 33.5 percent live below 200 percent of the federal poverty level.

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	4660706.0
Percent Below: 50% of poverty	7.9
100% of poverty	18.3
200% of poverty	41.6

Notes - 2011

Narrative:

Of the 4,660,706 children 19 and younger living in Florida, we estimate that 7.9 percent live below 50 percent of the federal poverty level. Approximately 18.3 percent live below 100 percent of the federal poverty level, and 41.6 percent live below 200 percent of the federal poverty level.

F. Other Program Activities

Childhood Lead Poisoning Prevention Initiative: A Department of Health program through which the environmental health program works with county health departments to enhance their data collection and case management capabilities for following and treating children with elevated blood lead levels.

Comprehensive Child Health Services: Child health services are provided to children age birth to 21 in most of the 67 county health departments in Florida. Counties may also contract services to private providers or other agencies. Comprehensive child health services are designed to integrate preventive health services and health promotion while minimizing cultural, geographic and financial barriers to care.

Every Woman Florida: A preconception health initiative that increases awareness on the importance of good preconception health. One of the goals of this initiative is to improve the integration of preconception health within all clinical settings. Another goal is to ensure the health of women of childbearing age. The Every Woman Florida website serves as a portal for preconception information for both providers and patients. The Every Women Florida Preconception Health Council is responsible for guiding the integration of preconception care in clinical and public health practice throughout Florida.

Family Health Line: A toll-free hotline that promotes the importance of early and continuous prenatal and infant care. The hotline provides basic information on pregnancy and how to access prenatal care, infant care, family planning, WIC, drug abuse treatment, and other pregnancy-related services. The hotline also arranges referrals to private, public, and volunteer health promotion groups. During 2009, there were 22,774 incoming calls to the Family Health Line.

Fetal and Infant Mortality Review: An information-gathering process designed to identify deficiencies in the maternal and infant health care system. Through individual case review, local FIMR projects attempt to identify factors that may contribute to fetal and infant death.

Florida Folic Acid Coalition: The Florida Folic Acid Coalition (FFAC) was created in 1999 to ensure that women in Florida and their health care providers are aware of the benefits of folic acid in decreasing the risk of birth defects of the brain and spine usually referred to as neural tube

defects. Comprised of public and private partners throughout the state, the group supports a wide range of educational activities that have contributed to documented increases in what health care providers and women of childbearing age know about folic acid. The coalition seeks to establish folic acid education as a routine and standard part of the delivery of preventive health care services, as well as increase awareness and education of the nutritional and health benefits of folic acid across the lifespan.

Pregnancy Associated Mortality Review: A population-based surveillance and selective case review process aimed at reducing maternal mortality in Florida. The PAMR project monitors trends in pregnancy-associated deaths, and identifies gaps in care, service delivery problems, and areas in which communities can facilitate improvements in the service delivery system for women.

Pregnancy Risk Assessment Monitoring System: The PRAMS project conducts population-based surveillance of selected maternal behaviors that occur during pregnancy and early infancy, in 35 states and the District of Columbia.

Reach Out and Read: An early literacy program that involves pediatricians and nurses supporting children's language and literacy development through various interventions.

Responsible Fatherhood Project: This project encourages fathers of children (age birth to 5) to become better fathers by making available resources, support, information and education. The project also seeks to increase awareness in the local community of the importance of fathers being actively involved with the care of their children.

Sexual Violence Prevention Program: The primary goals of the Sexual Violence Prevention Program (SVPP) are to provide statewide, integrated, primary rape prevention education; services to rape victims; county health department screening and assistance for domestic violence victims; and information on human trafficking. Additionally, the SVPP develops program and policy guidelines, responds to legislative issues, and manages a public awareness campaign called "Rape. Talk About It. Prevent It" comprised of radio and television public service announcements, and print media aimed to educate 10-24 year-olds about rape prevention.

Staff Development, Education and Training: MCH staff develops training materials targeted towards MCH providers. They provide ongoing training and technical assistance to increase skills needed to screen, assess, identify needs, coordinate and provide services.

State Early Childhood Comprehensive Systems (SECCS) Project: The purpose of the SECCS Project is to support state maternal and child health agencies and their partner organizations in collaborative efforts to strengthen the early childhood system of services for young children and their families. There are five focus areas of the project: access to medical homes, social-emotional development and mental health, parent education, early care and education services, and family support services.

Statewide Birth Defects Surveillance System: A system designed to reduce the impact of birth defects, investigate possible causative agents, disseminate information, and plan and evaluate the effects of interventions.

Sudden Infant Death Syndrome: The Department of Health oversees the professional support activities offered to people affected by SIDS. Activities focus on increasing the awareness of SIDS and providing the latest prevention information to health providers and trainers of secondary caregivers, such as childcare providers.

Voluntary Pre-Kindergarten: A program designed to prepare 4-year-olds for kindergarten and build the foundation for their educational success. The program allows a parent to enroll his or

her eligible child (four years old by September 1 and residing in Florida) in a free VPK program.

G. Technical Assistance

State performance measure 3, the percentage of women having a live birth who received preconception counseling about healthy lifestyle behaviors and prevention strategies from a health care provider prior to pregnancy. Request evaluation of the effectiveness our current counseling and education, and consultation on how preconception efforts might be strengthened and improved.

V. Budget Narrative

Budget and expenditure data from Forms 3, 4, and 5 are provided for the application year, interim year, and reporting year to assist the reviewer in analysis of the budget and expenditure narrative. For complete financial data, refer to all the financial data reported on Forms 2-5, especially when reviewing the federal allocation on Form 2 for the 30%/30%/10% breakdown for the budgets planned for primary and preventive care for children, children with special health care needs, and administrative costs.

Form 3, State MCH Funding Profile

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
1. Federal Allocation (Line1, Form 2)	19012075	19012075	19167334		19167334	
2. Unobligated Balance (Line2, Form 2)	0	0	0		0	
3. State Funds (Line3, Form 2)	169471378	187309301	169587822		169587823	
4. Local MCH Funds (Line4, Form 2)	0	0	0		0	
5. Other Funds (Line5, Form 2)	0	0	0		0	
6. Program Income (Line6, Form 2)	0	0	0		0	
7. Subtotal	188483453	206321376	188755156		188755157	
8. Other Federal Funds (Line10, Form 2)	329526694	260773895	341757522		586486272	
9. Total (Line11, Form 2)	518010147	467095271	530512678		775241429	

Form 4, Budget Details By Types of Individuals Served (I) and Sources of Other Federal Funds

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Federal-State MCH Block Grant Partnership						
a. Pregnant Women	17001208	13122039	20517685		33355546	
b. Infants < 1 year old	15059828	18176913	11230932		7603103	

c. Children 1 to 22 years old	65629938	74832764	67423342		66055792	
d. Children with Special Healthcare Needs	78069846	84798085	70707681		62865214	
e. Others	0	0	0		0	
f. Administration	12722633	15391575	18875516		18875502	
g. SUBTOTAL	188483453	206321376	188755156		188755157	
II. Other Federal Funds (under the control of the person responsible for administration of the Title V program).						
a. SPRANS	0		0		0	
b. SSDI	94644		94644		93713	
c. CISS	0		0		0	
d. Abstinence Education	2521581		2521581		0	
e. Healthy Start	0		0		0	
f. EMSC	0		0		0	
g. WIC	183058517		206263845		388339208	
h. AIDS	0		0		0	
i. CDC	12025475		11048460		13613334	
j. Education	0		0		0	
k. Other						
Others see notes)	0		0		33421773	
USDA CACFP grant	69175778		0		151018244	
Others (see notes)	0		39266239		0	
USDA CACFP	0		82562753		0	
others (see notes)	62650699		0		0	

Form 5, State Title V Program Budget and Expenditures by Types of Services (II)

	FY 2009		FY 2010		FY 2011	
	Budgeted	Expended	Budgeted	Expended	Budgeted	Expended
I. Direct Health Care Services	34303988	37550490	34353438		34353438	
II. Enabling Services	79351534	86861300	79465921		79465922	
III. Population-Based Services	25822233	28266029	25859456		25859456	
IV. Infrastructure Building Services	49005698	53643557	49076341		49076341	
V. Federal-State Title V Block Grant	188483453	206321376	188755156		188755157	

Partnership Total						
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A. Expenditures

There were no significant variations in expenditures in forms 3, 4, and 5 from previous years. Expenditure data for Florida is included on forms 3, 4, and 5.

B. Budget

Federal funding through the Title V MCH Block Grant provides needed support to our statewide efforts. Of the \$19,167,334 budgeted as the expected federal allotment for FY2011, \$6,707,702 is budgeted for preventive and primary care for children (35 percent), \$6,383,712 for children with special health care needs (33.31 percent) which meets the 30 percent-30 percent requirements. In addition, \$1,916,732 (10 percent) is budgeted towards Title V administrative costs. Total state match for FY 2011 is \$169,587,823, which exceeds the state's FY 1989 maintenance of effort amount of \$155,212,322. Sources of other federal funds include the SSDI grant, WIC, the USDA CACFP grant, the Preventive Health Services Block Grant, Florida's Medipass Waiver, and CDC grant awards. A complete list of other federal funds with funding amounts is included on Form 2 and the notes for Form 2. Budget numbers for Florida are included on forms 2, 3, 4, and 5.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

For the detail sheets and objectives for the state performance measures developed from the 2010 needs assessment, refer to TVIS Forms, Form 11 and Form 16 under the section "New State Performance Measure Detail Sheets and Data.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.